The Health Center

Application for Sliding-Fee Scale Discount Program

Phone: (802) 322-0704 Fax: (802) 454-8339 www.thcplainfield.org

1. Applicant

Name (Last)_____ (First)_____ (MI) _____

Street Address _____ City_____ State _____ Zip_____

Home Phone _____ Date of Birth_____ _____

Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

2. Tax Household Members *(Who would be listed on your tax return documents. Please include all household members on one form.)*

	Name	Relationship on Taxes	THC Patient? (Y/N)	Birth Date
1.				
2.				
3.				
4.				
5.				

3. Are you a College/University student? ☐ Yes ☐ No (If "Yes" you will need to supply a copy of your FAFSA to apply.)

Can you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

(If yes, additional income verification is required)

3a) Are you homeless? ☐ Yes ☐ No ☐ Transitional Housing

3b) If yes, please describe: _____

3c) Where are you staying?: _____

3d) How long will you be staying there?: _____

3e) Are you aware of homeless services in our community? ☐ Yes ☐ No

4. Total Tax Household Income

(Tax filers and all dependents)

Total Household Members

From Sections 1 & 2 _____

Income Calculation

Wages/Salary $_____ per_____ = $_____

Self-employment $_____ per_____ = $_____

Unearned (ex:Social Security)$_____ per_____ = $_____

Total Annual Gross Income $_____ (Specify type) _____

5. Insurance

Do you or your spouse have dental insurance coverage? ☐ Yes ☐ No Company _____

Do you or your spouse have health insurance benefits? ☐ Yes ☐ No Company _____

If yes, is it a Vermont Health Connect Policy? ☐ Yes ☐ No

☐ Insured - Insurance Provider:

☐ Uninsured

☐ Filled out State Insurance Application (Green Mountain Care/Medicaid)

☐ Application pending/Called GMC with patient to check application status

Do you have a medical and dental provider?

☐ Yes Medical Provider Name: _____

☐ No

☐ Yes Dental Provider Name: _____

☐ No Dental Provider

Are you interested receiving information about any of the following community services?

☐ Medical

☐ Dental

☐ Counseling ☐ Food Shelf ☐ Housing

Would you like us to connect you with services? ☐ Yes ☐ No

6. Signature

To the best of my knowledge, the above information is true and correct. I agree to inform the Center of any changes in my employment, financial status or housing. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated. (I also give permission for the Health Center staff to contact my employer or any other source to verify income.)

It is expected that all patients will be forthright and honest about their medical coverage and financial information. Intention-al omission or falsification of identity, financial, or demographic information is fraud and may result in dismissal from the practice for up to one year. In the event of falsification, the patient will be responsible for the full payment of services.

_____

Signature of Applicant **Date**

FOR HEALTH CENTER USE ONLY

Auth. Initials _____ Slide Level _____ Approval/Denial Date _____ Renewal Date _____

Please return this form with one of the following forms of income verification to The Health Center at PO Box 320, Plainfield, VT 05667:

- 2 consecutive paystubs from the last 30 days
- Social Security, disability or pension benefits statements
- IRS Form W2 or 1099
- FAFSA form
- Most recently filed tax return (form 1040)