❑ Original Application
❑ 6 month renewal
❑ 1 year renewal

Date Submitted:

Dept:

Financial Application

The information provided on this form is strictly confidential.
We use it to determine your discount according to your ability to pay for services rendered.

Rev 5-7-18

1 application per family
Include all household members- spouse and dependents!

PLEASE ATTACH

❑ Proof of income
2 Biweekly Paystubs
4 consecutive Paystubs
or Employer Letter

☐ Photo ID

❑ Tax Returns or Birth Certificates
(if you are stating you have dependents)
(if spouse is included as dependent also include their income)

Patient Information: (if patient is a minor parent/guardian information goes here)

First Name:	Middle:	Last:	Other Names:
Social Security #:	Date of Birth:	Phone #: ( )	❑ Home ❑ Cell
Address:	Suite/Apt	City:	State/Zip:
Do you have insurance? ❑yes ❑no Insurance payments will be applied to patient's total charges before sliding fee adjustment.		Marital Status (circle one): Single Married Separated Divorced Widowed	

Guarantor Information Same as Patient? ❑yes ❑no (If yes, do not fill in Guarantor Information)

First Name:	Middle:	Last:

All Other Household Members Information: Include Dependents and Spouse if married

**** Please attach TAX RETURN or Birth Certificates for proof of dependents ****

Name:	Relation:	Social Security #:	DOB
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Name:	Relation:	Social Security #:	DOB

Household income includes: Salaries, wages and tips from everyone included above, any dependent's income; net income from self employment; unemployment compensation, dividends and taxable interest; Social Security including disability payments, supplemental security income; alimony; cash support; rents; child suport; retirement or pension income...etc

Household "GROSS" Income (includes income from all individuals listed above):

Income	Source (self, spouse, etc., from above)	Amount	Document provided for proof	Frequency (Weekly, monthly, yearly)	Annualized Subtotal
Employment 1:					
Employment 2:					
Child Support					
Cash Support					
Other:					
				Total yearly household income:	

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. Should I have a change in status, I understand that it is my responsibility to notify Community Health Services as soon as possible. The discount fee arrangement has been discussed with me. I understand this discount will apply at each visit and that my portion of the fee is payable at the time services are provided.

❑ I was provided with a copy of this agreement ❑ Patient refused copy

Patient Name (Print) _____ Patient Signature X _____ Date:_____

CHS staff use only

❑ **Tax Return or birth certificates** — How many dependents are listed on the tax return/birth certificates attached? 1 2 3 4 5 6 7

❑ **Income Statements -4 weeks 2 Bi-weekly or Employer letter** — How often is the patient paid? No income --> ❑ Self declaration

Gross income only (include overtime)

Weekly	Every 2 weeks	Monthly	Periodically
1)	1)	Multiply by 12 1)	Attempt to estimate an annual salary or a letter on employer letterhead 1)
Add 1, 2, 3, 4 2)	Add 1, 2 2)		2)
Divide by 4	Divide by 4		
Multiply by 52 3)	Multiply by 52		3)
4)			4)
TOTAL	TOTAL	TOTAL	TOTAL

NOTES

CHS Patient Advocates: **Patient Advocate:** _____ **Date:** _____

Insurance Eligible ❑ Yes ❑ Refuses ❑ No ❑ Has Private Insurance

Slide Eligible ❑ Yes ❑ Refuses ❑ No

Slide Discount Eligibility

❑ Approved (circle Slide)

❑ Does not qualify

			Slide A (<= 100% FPL)	Slide B (101% - 125% FPL)	Slide C (126% - 150% FPL)	Slide D (151% - 200% FPL)	Slide E (over 200% FPL)
Patient Responsibility	Medical	All	$20	$40	$60	$80	Full Charge
	Dental	Most procedures *(additional lab fees may apply)*	$30	$40	$50	$60	Full Charge
		Other					
		Dentures (additional lab fees apply)	$500	$600	$700	$800	Full Charge
		Crowns, Bridges, Veneers, and Root Canals (additional lab fees may apply)	$200	$300	$400	$500	Full Charge
		Extractions	$60	$70	$80	$90	Full Charge
		Occlusal Guard (additional lab fees apply)	$60	$70	$80	$90	Full Charge
		Scaling (per quadrant)	$60	$70	$80	$90	Full Charge
		Fillings (per tooth)	$60	$70	$80	$90	Full Charge
		Cleaning of Dentures	$20	$20	$30	$35	Full Charge
		Sealants (per tooth	$10	$15	$20	$25	Full Charge

This arrangement is valid ***six (6) months, one (1) year*** (circle one) from the effective date, or the patient becomes eligible and elects insurance.

Effective date: _____ Expiration Date: _____

❑ Informed patient Date:_____

❑ Left voicemail Date:_____

Slide registered in Nextgen

❑ Medical

❑ Dental

CHS employee Please print: _____ Manager Approval (if necessary): _____

❑ Account reviewed by Billing Specialist Date:

Revised 01/31/2022