



- 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

PLEASE ATTACH

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

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

<input type="checkbox"/> Proof of income 2 Biweekly Paystubs 4 consecutive Paystubs or Employer Letter		<input type="checkbox"/> Photo ID	<input type="checkbox"/> Tax Returns or Birth Certificates (if you are stating you have dependents) (if spouse is included as dependent also include their income)
First Name:	Middle:	Last:	Other Names:
Social Security #:	Date of Birth:	Phone #: ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell
Address:	Suite/Apt	City:	State/Zip:
Do you have insurance? <input type="checkbox"/> yes <input type="checkbox"/> 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:
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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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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 support; 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 _____ 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)	1)	1)
Add 1, 2, 3, 4	Add 1, 2	Multiply by 12	Attempt to estimate an annual salary or a letter on employer letterhead
Divide by 4	Divide by 4		2)
Multiply by 52	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

		Slide A (≤ 100% FPL)	Slide B (101% - 125% FPL)	Slide C (126% - 150% FPL)	Slide D (151% - 200% FPL)	
<input type="checkbox"/> Approved (circle Slide)	Medical	All	\$20	\$40	\$60	\$80
<input type="checkbox"/> Does not qualify	Dental	Basic	\$30	25% of charges	50% of charges	75% of charges
		Major	25% of charges	35% of charges	50% of charges	75% of charges

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: _____

Slide registered in Nextgen

Medical
 Dental

Left voicemail Date: _____

CHS employee

Please print: _____

Manager Approval (if necessary): _____

Account reviewed by Billing Specialist

Date: _____