Financial Assistance Application

PROOF OF INCOME is required as explained below.

PRIMARY APPLICANT (PARENT IF THE PATIENT IS A MINOR)

Last name______________________ First________________ Middle__________

Date of Birth ____________ Phone _______________

Mailing address____

Are you currently enrolled in: Medicaid? ❑ Yes ❑ No Medicare? ❑ Yes ❑ No

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Last name______________________ First________________ Middle__________

Date of Birth ____________ Phone _______________

Mailing address____

Are you currently enrolled in: Medicaid? ❑ Yes ❑ No Medicare? ❑ Yes ❑ No

DEPENDENT'S INFORMATION

(Please note: only dependents you claimed on your Federal tax return may be included here-attach a piece of paper for additional dependents if needed)

Last name__________________ First__________ Middle_____ DOB __________

Last name__________________ First__________ Middle_____ DOB __________

Last name__________________ First__________ Middle_____ DOB __________

Are any of your dependents currently enrolled in: Medicaid? ❑ Yes ❑ No Medicare? ❑ Yes ❑ No

If yes, which dependent(s)____

THIS APPLICATION APPLIES TO ALL OF OUR PRACTICES (some services may not apply)

- **Morrisville Family Health Care • Stowe Family Practice • Neurology Clinic**
- **Community Dental Clinic • Behavioral Health & Wellness Center • Appleseed Pediatrics**

ESTIMATED MONTHLY HOUSEHOLD INCOME - ***Proof of income must be provided, which may include, a copy of a recent pay stub, Social Security determination letter, or tax return if self-employed.***

Gross wages (before tax) $__________

Pensions $__________

Social Security $__________

Worker's Compensation $__________

Unemployment $__________

State/Federal Assistance $__________

Alimony Received $__________

Other Income $__________

(Please Specify) ________________

USE OF PERSONAL FINANCIAL INFORMATION DISCLOSURE, AUTHORIZATION AND RELEASE FOR APPLICATION FOR ASSISTANCE

I hereby authorize CHSLV to utilize the financial information I am providing, to process my application for financial assistance as a patient at CHSLV. I certify all of the information provided on or with this application is true and accurate.

❑ PROOF OF INCOME ENCLOSED?

(Proof of income must be provided within 7 business days to be eligible for any discount you may receive today)

________________________ Signature of Primary Applicant

__________ Date

Return this completed application, along with your proof of income, to your Physician's Office or mail to: CHSLV, P.O. Box 749, Morrisville, VT 05661