Complete and Return by: _____

Fee Discount Application

If you need help filling in information below please see a Patient Eligibility and Enrollment Specialist.

STEP ONE: Applicant Information

Applicant Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____
Street Apt. City State Zip Code

Tax Filing Status: _____ Adjusted Gross Income: _____ Social Security Number or Tax ID Number: _____

STEP TWO: Health Insurance

Do you have medical or dental insurance?

◯ Yes ◯ No

If yes, what is your:

Plan Name(s):

_____

_____

Plan #:

_____

_____

STEP THREE: Only if applying with co-applicant or have dependents.

Dependent(s)	Relationship	Date of Birth	Social Security or Tax ID Number	IRS Tax Filing Status	Adjusted Gross Income
A co-applicant or dependent must meet the following to qualify: Must be a spouse, son, daughter, stepchild, foster child, brother, sister, half-brother, half-sister, stepbrother, stepsister, or a descendant of any of them. If a child, must be (a) under age 19 at the end of the year, (b) under age 24 at the end of the year, if a student, or (c) any age, if dependent is disabled.				**NF** Non-Filer (don't file taxes) **MFJ** Married Filing Jointly **MFS** Married Filing Separately **SGL** Single **HH** Head of Household **Dep** Dependent	Adjusted Gross Income as stated on your prior year taxes. If you did not file taxes you will need to complete CHC's Verification of Household Income – PA Form 201B.
Example: Jane Smith	*Child*	*MM/DD/YYYY*	*123-45-6789*	*Dep*	*$0*

STEP FOUR:

To the best of my knowledge, the information given is true and correct. I give Community Health Center of Snohomish County permission to verify information about my financial status. **I understand this information and all supporting documentation must be provided within 30 days of the date of visit to qualify for sliding fee discount.** If this information is not received, then I understand that I will be responsible for the full cost for the visit.

_____ _____
Applicant/Guarantor Signature Today's Date

Internal Use Only:

Clinic Received: _____ CHC staff Name (Printed): _____ NG #: _____ A#: _____

Verified annual income: $_____ # in household: _____ Sliding Scale: _____ Recertification Date: _____

Proof of income: ◯ IRS ◯ PA Form 201B ◯ Other (specify): _____ PEES or Billing Staff Name and Signature: _____