Need help signing up for health care?

ARLINGTON CLINIC
Medical / Dental / Pharmacy
326 S. Stillaguamish Ave., Arlington, WA 98223
(360) 572-5400

EDMONDS CLINIC
Medical Primary Care & Walk-In / Dental / Pharmacy / Physical Therapy
23320 Hwy. 99, Edmonds, WA 98026
(425) 640-5500

EVERETT-CENTRAL CLINIC
Medical Primary Care & Walk-In / Dental / Pharmacy / Physical Therapy
4201 Rucker Ave, Everett, WA 98203
(425) 382-4000

EVERETT-COLLEGE CLINIC
Medical Primary Care
930 North Broadway, Everett, WA 98201
(425) 595-3900

EVERETT-NORTH CLINIC
Medical / Dental / Pharmacy
1424 Broadway, Everett, WA 98201
(425) 789-2000

EVERETT-SOUTH CLINIC
Medical / Dental / Pharmacy
1019 112th St. SW, Everett, WA 98204
(425) 551-6200

LYNNWOOD CLINIC
Medical / Dental / Pharmacy
4111 194th St. SW, Lynnwood, WA 98036
(425) 835-5200

*All CHC Dental Clinics offer Walk-In services.

www.CHCsno.org

(425) 789-3789 • TTY Relay, dial 711

CHC Community Health Center OF SNOHOMISH COUNTY

Application for Sliding Fee Discount

Please fill out this form in its entirety, with supporting documentation of total household (yourself and dependents claimed on your recent taxes) income, within 30 days of the date of visit.

Date of Service: _____

Last Date to submit: _____

Required supporting documents:

- ☐ Sliding Fee Discount Application with all household members (dependents claimed on your recent taxes) included on the application.
- ☐ Copy of last year's taxes to verify Adjusted Gross Income.
- ☐ Verification of Household Income form and proof of Income **IF** any of the following apply to you:
  - Your income has changed since you last filed your taxes.
  - You do not file taxes.

If application is incomplete or missing supporting documentation it will be returned and not considered received until resubmitted as complete.

Compassionate. Affordable. Accessible.

CHC Community Health Center OF SNOHOMISH COUNTY

Complete and Return by: _____

Fee Discount Application

If you need help filling in the information below, please see a Patient Services 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: _____