Complete and Return by: ________________________

Fee Discount Application

If you need help filling in information below, please see a Patient Service 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):__________ PSS or Billing Staff Name and Signature: ______________________________

CHC Community Health Center OF SNOHOMISH COUNTY

Verification of Household Income

List Income For Last 30 Days	
Add:	
Wages, salaries, tips, etc. *(attach a pay stub)*	$
Social Security benefits *(attach award letter or bank statement)*	$
Taxable interest or dividends *(attach bank statement)*	$
Taxable pension, annuity or IRA distributions *(attach bank statement)*	$
Unemployment compensation or Workmen's compensation *(attach award letter or bank statement)*	$
Business income *(attach IRS Schedule C)*	$
Income from rental real estate, trusts, royalties, partnerships, S corporations, etc. *(attach IRS Schedule E or bank statement)*	$
Farm income *(attach IRS Schedule F)*	$
Alimony received *(attach bank statement)*	$
Other income *(list type and provide supporting documentation)*	$
Minus:	
Alimony paid *(attach bank statement)*	$
Total Household Income:	**$**

To the best of my knowledge, the information given is true and correct. I understand additional information may be requested and I will submit it within 14 days of the request. I give CHC permission to contact me to verify the above information and understand if this statement is not completed to its full extent, the application for a discount may be denied.

_______________________________ _______________________________

Printed Name *Contact Telephone Number*

_______________________________ _______________________________

Signature *Date*

Self-Declared No Income

How are you receiving food and shelter? _______________________________

____

____

I attest that my household has no income.

_______________________________ _______________________________

Signature *Date*