

Carlos G. Otis Health Care Center, Inc.

Sliding Fee Scale Eligibility Application for Account # _____

Household Member information: Number of household members _____

List all household members

- | | |
|----------|----------------------|
| 1. _____ | Date of Birth: _____ |
| 2. _____ | Date of Birth: _____ |
| 3. _____ | Date of Birth: _____ |
| 4. _____ | Date of Birth: _____ |
| 5. _____ | Date of Birth: _____ |

Have you applied for VT Medicaid? Y or N – If yes were you denied? Why?

Proof of Income Verification: The following are types of proof that can be used for verification: Paycheck stubs (preferably 3 months, minimum 1 month); Statement from employer as proof of wages when stubs are not available; Statement from unemployment income; Statement from Social Security or Disability; Annual W-2 wage statements from all sources; Gross income determination from IRS tax return form; Bank account statements for self-employed.

Patient Declaration and Signature:

By signing below, I declare that, as of the date of my signature, the income sources I have provided constitute all of my household income, and the household members listed above are all solely dependant on that income, or that the explanation provided to verify my income is truthful.

Signature: _____ Date: _____

Office Use Only

If proof of income is not available, an explanation for determining eligibility may be provided and initialed below by the VP of Clinic Services at the time of application.

Attach income source to the application and file together.

Family Size	(<100%) 100% discount	(100 – 125%) 80% discount	(126-150%) 60% discount	(151-175%) 40% discount	(176-200%) 20% discount	(>200%) 0% discount
1	10830	10831 - 13538	13539 - 16245	16246 - 18953	18954 – 21660	21661 - above
2	14570	14571 – 18213	18214 – 21855	21856 – 25498	25499 – 29140	29141 – above
3	18310	18311 – 22888	22889 – 27465	27466 – 32043	32044 – 36620	36621 – above
4	22050	22051 – 27563	27564 – 33075	33076 – 38588	38589 – 44100	44101 – above
5	25790	25791 – 32238	32239 – 38685	38686 – 45133	45134 – 51580	51581 - above

Add \$3740 for each addition person

Gross income: _____ Sliding fee scale qualified for: _____

Income must be verified at each visit? YES NO

Signature _____ Finance Department _____ Date _____