Cape Cod Community Health Center

Exhibit A1

ANNUAL REQUEST FOR ELIGIBILITY FOR SLIDING FEE SCALE DISCOUNT PROGRAM

As provided for by Federal Law, I hereby request that the **Community Health Center of Cape Cod** make a written determination of my eligibility for a Sliding Fee Scale for services rendered at the **Community Health Center of Cape Cod**. I understand the information which I submit concerning my annual income and family size is subject to verification by the **Community Health Center of Cape Cod** and authorize all necessary means to verify the information provided by me. I also understand that if the information which I submit is determined to be false, such determination will result in denial of approval for participation in the Sliding Fee Scale Discount program and I will be liable for the full charges of the services rendered to me. I authorize you to release any information acquired in the course of my examination or treatment to the Department of Medical Security or its designee.

The information requested will be held in the strictest of confidence and will be used solely for the purpose of determining Sliding Fee Scale Discount Program eligibility.

Name ______________________ Date of Birth ______________________

Address ______________________ Telephone ______________________

PLEASE LIST BELOW ALL HOUSEHOLD MEMBERS (See attached)

FIRST/LAST NAME	RELATIONSHIP	DATE OF BIRTH	PATIENT *(CIRCLE ONE)*	INSURED *(CIRCLE ONE)*
1.			YES / NO	YES / NO
2.			YES / NO	YES / NO
3.			YES / NO	YES / NO
4.			YES / NO	YES / NO
5.			YES / NO	YES / NO
6.			YES / NO	YES / NO

(Please add more lines as necessary)

INCOME VERIFICATION FOR THE HOUSEHOLD MUST BE SUBMITTED IN ORDER TO PROCESS THIS APPLICATION.

(e.g. Tax Return, SS, Disability, Unemployment Documents, Pay Stubs, or W2s)

MISSING INFORMATION AND/OR DOCUMENTATION WILL RESULT IN A DELAY IN PROCESSING.

PATIENT (OR GUARDIAN) ______ DATE OF BIRTH ______ SOCIAL SECURITY (Optional)

HEAD OF HOUSEHOLD ______ DATE OF BIRTH ______ SOCIAL SECURITY (Optional)

RELATIONSHIP ______ SIGNATURE ______ DATE

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SOURCES OF MONTHLY INCOME **MONTHLY AMOUNT**
(Complete all that apply)

Full-time, **P**art-time or **S**elf-employed (Circle below)

______________________________ F P S $______________
Company Name – Current Job 1 (Optional)
______________________________ F P S $______________
Company Name – Current Job 2 (Optional)

Unemployment Compensation $______________

Workman's Compensation $______________

Social Security Benefits $______________

Retirement or Disability $______________

Alimony or Child Support $______________

Welfare or Other State Aid

Other Income (specify)______________________________ $______________

TOTAL INCOME **$**______________

Per Waiver of Fees Application (Hardship determined)

Total Annual Income______________________________

Medically Necessary Expenses ______________________________

Adjusted Income__________Family Size__________SFS% ______________

SLIDING FEE SCALE ELIGIBILITY DETERMINATION
(CIRCLE) YES /NO

Services seeking: (CIRCLE) Medical Dental Eyecare Behavioral Health Pharmacy Other (specify)

CHCCC REVIEWER (STAFF) NAME:______________________________

APPROVAL DATE:______________________________

Eligibility for the program is for a one year period. A new application will be required a year from approval date.