Sliding Fee Application

Application Date:
Applicant's Name:
Applicant's Address:
Phone #:

PROOF OF CURRENT HOUSEHOLD INCOME AND EXPENSES: YOU MUST PROVIDE A LETTER, WRITTEN STATEMENT, OR COPY OF CHECK STUBS (2-4), FROM THE EMPLOYER, PERSON OR AGENCY PROVIDING THE INCOME. SUBMIT ALL THAT APPLY. PROVIDE THE MOST RECENT PROOF OF INCOME BEFORE TAXES. THE PROOF MUST BE DATED, INCLUDE THE EMPLOYEE'S NAME AND SHOW GROSS INCOME FOR THE PAY PERIOD.

Contact Information

First Name:	Middle Initial:	Last Name:
Phone #:		

Home Address

Street:		Apt #:
City:	State:	Zip Code:

Mailing Address (if different than Home Address)

Street:		Apt #:
City:	State:	Zip Code:

Household Information

List the head of household in line 1. List the name of spouse or significant other on line 2 List the names of dependent children on lines 2-10.

	Name (First, Middle Initial, Last)	Date of Birth	Sex	Relationship to Head of Household	Social Security #
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

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By signing my name below, I attest that all of these statements are true and that I do not have access to other medical insurance through the federal government, the state, an employer or on my own. I also understand that I am applying to VT / NY Medicaid before I can be approved for the Community Health Sliding Fee Scale.

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(Signature of guarantor) (Date)