

**THIS APPLICATION CANNOT BE PROCESSED WITHOUT
PROOF OF INCOME as explained below.**

PRIMARY APPLICANT (PARENT IF THE PATIENT IS A MINOR)

Last name _____ First _____ Middle _____

Date of Birth _____ Phone _____

Mailing address _____

Are you currently enrolled in: Medicaid? Yes No Medicare? Yes No

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Last name _____ First _____ Middle _____

Date of Birth _____ Phone _____

Mailing address _____

Are you currently enrolled in: Medicaid? Yes No Medicare? Yes No

DEPENDENT'S INFORMATION

(Please note: only dependents you claimed on your Federal Tax return may be included here-attach a piece of paper for additional dependents if needed)

Last name _____ First _____ Middle _____ DOB _____

Last name _____ First _____ Middle _____ DOB _____

Last name _____ First _____ Middle _____ DOB _____

Last name _____ First _____ Middle _____ DOB _____

Are any of your dependents currently enrolled in: Medicaid? Yes No Medicare? Yes No

If yes, which dependent(s) _____

PLEASE CHECK THE PRACTICES FOR WHICH YOU ARE APPLYING FOR ASSISTANCE

Morrisville Family Health Care Stowe Family Practice The Women's Center

Behavioral Health & Wellness Center Dental Clinic

ESTIMATED MONTHLY HOUSEHOLD INCOME - *Proof of income must accompany this application. Copy of a recent pay stub, Social Security determination, and/or tax return if self employed*

Gross wages	\$ _____	ANFC Assistance	\$ _____
Pensions	\$ _____	Alimony Received	\$ _____
Social Security	\$ _____	Alimony Paid	\$ (_____)
Workers Comp	\$ _____	Child Support Received	\$ _____
Unemployment	\$ _____	Child Support Paid	\$ (_____)
Checking balance (current)	\$ _____	Savings balance (current)	\$ _____

USE OF PERSONAL FINANCIAL INFORMATION DISCLOSURE, AUTHORIZATION AND RELEASE FOR APPLICATION FOR ASSISTANCE
I hereby authorize CHSLV to utilize the financial information I am providing, to process my application for financial assistance as a patient at CHSLV. I certify all of the information provided on or with this application is true and accurate.

PROOF OF INCOME ENCLOSED?



Signature of Primary Applicant or Guarantor

Date



COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY

Return this completed application, along with your proof of income, to your Physician's Office or mail to: CHSLV 530 Washington Highway, Suite 12 Morrisville, VT 05661