The CIFIC Greater Danbury Community Health Center (GDCHC) offers a sliding fee schedule to provide financial assistance to all patients who qualify based on income, regardless of whether the patient carries health insurance coverage.

The CIFIC Greater Danbury Community Health Center makes a determination as to a patient’s potential eligibility for financial assistance based on the information provided on the patient’s intake form. Any patient who indicates that she/he may be income eligible on their intake form is screened by the GDCHC Office Coordinator or designee. (Outreach Enrollment Specialists will be contacted to assist patients with enrollment in qualified health plans through Access Health CT and/or assist patients with Medicaid enrollment, which is also completed through the Access Health CT website.) Potentially eligible patients are then required to complete the attached form and provide verification of their household income.

The following documentation is required to verify income:

If the individual is paid wages, s/he is required to provide one of the following:
   (1) A most recent income tax return; OR
   (2) Most recent W2 Form; OR
   (3) 2 current, consecutive pay stubs.

If the individual is paid in cash, s/he is required to provide both:
   (1) A most recent income tax return, which includes a Schedule C form; AND
   (2) A letter from his/her employer, on the employer’s letterhead, stating the employee’s hours, days worked, and amount earned weekly.

If the individual is self-employed, s/he is required to provide the following:
   (1) A most recent income tax return, which includes a Schedule C form, AND a self attestation letter indicating weekly or monthly income and/or profit and loss statement; OR
   (2) Three (3) months worth of bank account statements AND a self attestation letter indicating weekly or monthly income and/or profit and loss statement.

As applicable, these documents shall also serve to verify income in the case of unemployment or disability:
   (1) Social Security Income Statement;

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1 See GDCHC Sliding Fee Schedule Policy for ALL applicable details.
(2) SSI Supplemental Security Income Statement;
(3) Disability Income Statement; or
(4) Unemployment Income Statement.

***All patients deemed eligible for financial assistance must verify their income annually in order to continue to receive financial assistance.***
As a federally qualified health center, we are required to obtain the following information in order to determine your eligibility for a discount on your medical expenses. This information will be kept on file in our health center in strict confidence. You must verify your income annually.

Patient’s Name: ___________________________________/_________________________________/_________________________________

Date of Birth: _________(month)/________(day)________(year)  Today’s Date: _________(month)/________(day)________(year)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Are you Head of Household?</th>
<th>Number of People Living in Your Home:</th>
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<tbody>
<tr>
<td>□ Single  □ Married  □ Separated</td>
<td>□ Yes □ No</td>
<td></td>
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<tr>
<td>□ Divorced □ Widowed</td>
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</tbody>
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Annual Household Income

Household Income includes wages and salaries before deductions, including tips, as well as social security, public assistance (excluding food stamps and housing assistance), retirement/pension, rental income, interest income, child support, alimony of all persons who occupy a housing unit (house or apartment) whether or not they are related to each other (e.g., spouse, life partner, or any relative/non-relative contributing to the household income).

<table>
<thead>
<tr>
<th>Name of Household Member</th>
<th>Relationship to Applicant</th>
<th>DOB</th>
<th>Income Source</th>
<th>How Much?</th>
<th>How Often</th>
<th>Annual Income (Staff Use Only)</th>
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</table>

I declare the above information is true and I give permission to the CIFC Greater Danbury Community Health Center to investigate any information given in this application. I acknowledge that submission of false information is punishable under state and federal law. I understand that this information will be kept in strict confidence. I also understand that if my income should change, I am required to notify the receptionist on my next visit to the Health Center.

Patient/Guardian Signature:__________________________________________ Date:_____________________

New, 09/2012, Revisions Approved: QA/QI: 04/20/15; Board: 04/22/2015