Battenkill Valley Health Center
Application for Sliding Fee Program

*** Return to the office with proof of income and proof of physical address ***

1. Applicant

Name (Last) (First) (MI)

Physical Address City State Zip

Preferred Phone Date of Birth SS#

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Union

2. Household Members (Include spouse, dependent children, relatives and others that live with you)

Name	Relationship	Birth Date	Social Security #
1.			
2.			
3.			
4.			
5.			

Have you applied for State Healthcare? ☐ Y ☐ N Are you homeless/doubling up? ☐ Y ☐ N

Results of application: Are you a tourist or foreign student? ☐ Y ☐ N

Are you a College/University student? ☐ Y ☐ N

If yes, can you be claimed as a dependent on someone else's tax return? ☐ Y ☐ N *(If yes, additional income verification is required)*

3. Total Income of Family (anyone on your income tax return)

Total Household Members:

Wages/salary for all $ per not applicable

Self-employment income for all $ per not applicable

Unearned sources of income for all $ per not applicable

Total Annual Income $

4. Insurance

Do you or your spouse have medical insurance benefits? ☐ Y ☐ N

5. Signature

To the best of my knowledge, the above information is true and correct. I agree to inform BVHC of any changes in employment, household size, household income, insurance status or financial status for anyone listed on this application. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated. I also give permission for the BVHC staff to contact my employer or any other source to verify income.

_____

Signature of Applicant Date

FOR BVHC USE ONLY

Authorizer Initials _____ Fee Level _____ Approval/Denial _____ Date _____ Expiration Date _____