Mora Valley Community Health Services, Inc.

P.O. Box 209 Mora, New Mexico 87732

Medical/Behavioral Health: Phone: (575) 387-2201 Fax: (575) 387-9006
Dental: Phone: (575) 387-2481 Fax: (575) 387-9149
School Based Health Center: (575) 387-3117

OFFICE USE ONLY
Code_____
Date Application given:_____
Date Received:_____
Date in Computer:_____
Date letter sent requesting further documentation:_____
Effective Dates:_____

Sliding Fee Program Application

Patients may be deemed eligible for the sliding fee scale for one (1) visit with completion of this application. Patient must bring in all documentation requested by the 2nd visit to remain on the Sliding Fee Scale.

Name: _____ Telephone: _____
Mailing Address: _____
PO Box or Street Town State Zip Code

Town of residence if different than mailing address: _____

Have you been enrolled in the Sliding Fee Program before? ☐ Yes ☐ No

HOUSEHOLD INFORMATION

Please list ALL MEMBERS of your household (include yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes. **If child is over 18, indicate if student.**

Household Members Names	Birth Date	Social Security Number	Relationship to Applicant
			Self

☐ I have no health insurance coverage.
☐ I have health insurance coverage through _____.

Please fill out the income information section on the next page for ALL members of family. If you have no source of income, please go to zero income section on next page.

Mora Valley Community Health Services is an Equal Opportunity Organization.

INCOME INFORMATION

Source of Income	Name of Source	Gross Annual Income
Wages		
Self-employed (net receipts after deductions)**		
Social Security Benefits (SSI, Survivor's, Disability)		
Public Assistance (TANF, General Assistance, etc.)		
Child Support/Alimony		
Unemployment Benefits, Workers' Compensation		
Stocks, Dividends, Rental Property		
Interest Income		
Other (Pensions, Veteran's Benefits, etc.)		

****If you are self-employed, you must bring a copy of 1040 with schedule C attached, latest 12 months of Gross Receipt Tax, and or a Profit and Loss Statement.**

YOU MUST INCLUDE PROOF OF INCOME SUCH AS FEDERAL TAX RETURN; MEDICAID, MEDICARE, OR SOCIAL SECURITY AWARD LETTERS AND CHECK STUBS; AND/OR COPIES OF UNEMPLOYMENT CHECKS.

Without proof of income your application will not be processed and your enrollment into the program will be delayed. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

ZERO INCOME

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: _____ Date of last employment: _____

Please explain how your basic needs have been met:

Food: _____ Utilities: _____

Shelter: _____ Non-food items (clothing, etc.): _____

I, _____, certify that I have had no source of income since _____.

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW

- I agree to be responsible for my Health Center bills.
- I also agree to tell the Health Center if I become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the information I have given on this application is complete and true.

Signature _____ Date: _____

Help is available in applying for Medicaid or other state coverage insurance. Please inquire at front desk.