Revised: 2018-06

Commonwealth Healthcare Corporation

Care and Resources Assistance

Please complete the following application to determine eligibility for the Sliding Fee Discount Program.
If you do not qualify for Medicaid, attach copy of you Denial Letter from Medicaid Program. Completed applications should be returned from Monday through Friday, except holidays, between 7:30am-4:00pm or contact 234-8950 Ext.3502.

First Name:	**Middle:**	**Last:**	
Mailing Address:	**City:**	**State:**	**Zip:**
Phone #:	☐ **Male** ☐ **Female**	**Date of Birth:**	
Marital Status: ____Married ____Single ____Divorced ____Widow ____In a Relationship		**SSN (if applicable) _____**	

Household Members	**FULL NAME**	**Date of Birth** Month/Day/Year	**Social Security Number**	**Relationship**	**Current Employer**

Income	**Monthly/Annual Income**	**For YOU**	**For SPOUSE**	**For Children**	**For Other**	**Subtotal**
	Gross wages, salaries, and tips					
	Social security & pensions					
	Annuity & veteran benefits					
	Child support & alimony					
	Self-employment & Other					
					TOTAL	

I agree to the release of personal and financial information from this application to determine eligibility.

I understand that no information on this application will be shared with the United States Citizenship and Immigration Services, Immigration and Customs Enforcement, nor any other entity other than those necessary to determine eligibility.

I understand that I may be asked for more information.

I agree to immediately report any changes to the information on this application.

I attest that the above information is true and correct to the best of my knowledge.

I understand that anyone who knowingly lies or hides the truth in order to receive services under this program may be subject to applicable federal and state penalties.

I understand that should it be discovered that I knowingly provided false information on this application, the Commonwealth Healthcare Corporation reserves the right to hold me personally responsible to repay the amount of benefits received unjustly and that I may also be assessed civil penalties.

SIGNATURE:_____ **DATE:**_____

NOTE: Please include copies of tax returns, pay stubs and any other information verifying income for ALL eligible household members. Please use the document checklist to ensure you have attached all necessary materials. **Applications will NOT be processed without required information.**

FOR OFFICIAL USE ONLY

Verified Annual Household Income: $_____ **# In Household:** _____

Proof of Income: W-2 Pay Stubs Letter from Employer NAP Enrollment 1040 1099 OTHER(Specify):_____

Financial Officer:_____ **Approved Disapproved Sliding Scale: 100 75 50 25**

AFFIDAVIT OF LIVING ARRANGEMENT & SUPPORT

I, _____ hereby depose and state the following under penalty of perjury;

I am an adult of legal age and a citizen of the _____ and a resident of the Commonwealth of the Northern Mariana Islands (CNMI). I am presently residing in _____ village (Saipan, Tinian, Rota), CNMI. I am _____ years old with Social Security No._____. I have made (Saipan, Tinian, Rota) my permanent and exclusive domicile residence.
I am presently residing at the residence of _____
(Relationship: _____), Free of charge/and/or Rent Fee of $_____.
Included: ( ) Utility, Water & Sewer—Not Included ( ) $_____.
Support for the household comes from _____
(Relationship:_____). ( ) Food & Lodging or ( ) Monetary $_____
I declare under penalty of perjury that foregoing is true and correct. This affidavit is executed on the _____ day of _____ year (_____)

_____ _____

Landlord, Print Name & Signature ***Affiant Signature***

Contact Number: _____

Commonwealth Healthcare Corporation Care and Resource Assistance

SELF-DECLARATION OF INCOME AND RESIDENCY

I, _____, do hereby declare on _____(date) that:
I have no documented proof of income due to the following situation:

_____

_____

_____

My monthly expenses are:

Housing (rent/mortgage payment) _____ Transportation _____

Food _____

Utilities _____

Medical _____

TOTAL _____

My household consists of _____ (#) of persons and the following household members have earned the following gross income during the **30-day period** prior to the date of application.

Name: _____ Gross Amount Earned: _____

Name: _____ Gross Amount Earned: _____

TOTAL GROSS INCOME: _____

I certify that the above information for the income of all household members is true and correct to the best of my knowledge and belief.

I understand that if I knowingly provide false information on this self-declaration form, that the Commonwealth Healthcare Corporation reserves the right to hold me personally responsible to repay the amount of benefits received unjustly, and to assess civil penalties.

_____ _____

(Applicant Signature) *(Date)*

_____

(NOTARY PUBLIC)