Commonwealth Healthcare Corporation

Sliding Fee Program Application

Please complete the following application to determine eligibility for the Sliding Fee Discount Program. Completed applications should be returned to the CARA office from Monday through Friday except holidays.
Office hours 7:30am -4:30pm, Contact No. (670) 234-8951 ext. 1230 or 1231

First Name:	**Middle:**	**Last:**	
Mailing Address:	**City:**	**State:**	**Zip:**
Phone No.:	**Other Contact No.:**	**Date of Birth:**	

Household Members	FULL NAME	Date of Birth Month/Day/Year	Relationship to Applicant	Current Employer

Income	Monthly/Annual Income	For YOU	For SPOUSE	For CHILDREN	Subtotal
	Gross wages, salaries, and tips				
	Social security, workers compensation, retirement &pensions				
	Annuity & veteran benefits				
	Child support & alimony				
	Business and Self-employment				
				TOTAL:	

** I understand the discount will only be applied to my primary care services at the outpatient clinics at CHCC.*

** 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 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 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.*

Applicant Print & Sign: _____ DATE:_____

FOR MAIN OFFICE USE ONLY

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

Proof of Identification/Address: Driver's License Utility Bill Passport OTHER(Specify):_____

Proof Of Income: W-2 Pay Stubs Letter from Employer OTHER(Specify):_____

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

Revised: Feb-2026

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 this date_____ that I have no documented proof of income due to the following situation:

_____

_____

_____

My estimated Expenses within a month 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 Print and Sign *Date*