VALLEY HEALTH PARTNERS

# Sliding Fee Discount Program Application

Valley Health Partners Community Health Center will serve all patients regardless of ability to pay. As an FQHC, VHPCHC will not discriminate based on race, color, sex, national origin, disability, religion, sexual orientation, or ability to pay.

**Patient Information**

Patient Name: ______________________________________________________________________________

Address: __________________________________________________________________________________

Date of Birth: ______________ Social Security Number: ________-_____-_________ Phone#: (          ) ________-_______

Employer Name: ______________________________________ Household Size: _________________________________

(the number of people living in your home)

Marital Status:____Single____Married____Divorced____Widow(er)

**Family/ Household Income Information**

| Name | Date of Birth | Social Security # | Relationship to Applicant | Enrolled as a patient of VHPCHC |
|---|---|---|---|---|
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |

**Household Income**

Please provide proof of income from the last 30 days. Acceptable proof of income includes, but is not limited to, pay stubs, Social Security benefits, VA benefits, pension, unemployment benefits, or the previous year's income tax return, including the schedule C. If you have no source of household income during this time period, please complete the self-declaration form.

| Income Source | Self | Spouse | Other | Total |
|---|---|---|---|---|
| **Gross wages, salaries, tips, etc.** | | | | |
| **Income from business, self-employment, and dependents** | | | | |
| **Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement** | | | | |
| **Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources** | | | | |
| **Total Annual Household Income** | | | | |

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

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**Notice to Applicants**

To be assessed for the Sliding Fee Discount Program, applicants must provide the financial counselor the requested information as indicated on the application.

Approved adjustments apply to all fees falling within the eligibility period, for services rendered within Valley Health Partners Community Health Center

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I certify that all of the above statements are true and accurate to the best of my knowledge. Authorization is hereby given to Valley Health Care to verify in any manner it deems appropriate any items indicated on this statement If any information I have given proves to be untrue, I understand that Valley Health Partners may re-evaluate my financial status and take whatever action becomes appropriate.

I also understand that if I am approved for the Sliding Fee Discount Program, my Sliding Fee payment is due at the time of service. However, payment arrangements are available if you are unable to pay the entire fee.

**Applicants Signature:** ______________________________________________ **Date:** ____________________

**Co-Applicants Signature:** ____________________________________________ **Date:** ____________________

## OFFICE USE ONLY

| Verification Checklist | Yes | No |
|---|---|---|
| Identification/Address: Driver's license, utility bill, employment ID, or | | |
| Income: Prior year tax return, three most recent pay stubs, or other | | |
| Income: Self-Declaration Form (if applicable) | | |
| Insurance: Insurance Cards | | |

**Application Completion Date:** __________

| Office Use Only | | | | |
|---|---|---|---|---|
| **Eligible:** | **Ineligible:** | **Qualifies for %:** | **Date of Determination:** | **Does not qualify because:** |
| | | | | |

**Financial Counselor/PSR Signature:** ________________________________________ **Date:** _________________

**Audited By:** ______________________________________________________ **Date:** ____________________