



APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

Legal Name: _____ Birth Date: _____

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different than mailing): _____

Email Address: _____ @ _____

Telephone #: Home: _____ Cell: _____ Work: _____

Marital Status Single Married Divorced Widowed

List any full time students in the home: _____

List any changes to Insurance: _____

List of Family/Household members: If more space is needed, attach a separate sheet	Date Of Birth	Relation To Applicant	Insured Yes or No	List Income Type Wages, unemployment, pension, Social Security, alimony, rental income, investment, other taxable income	Amount Per Month Before Taxes (self-employed net)
		Self			

Number of people living in your household: _____ **Monthly Gross Total:**

Applicant's employer: _____ Paid How Often? _____ Start date: _____

Other household member's employer: _____ Paid How Often? _____ Start date: _____

If unemployed, date of last paycheck: _____

Please list the monthly amount you receive of:

SNAP Amount \$ _____	Child Support \$ _____	SSI \$ _____	Veteran's Benefits \$ _____	Other: _____
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DECLARATION: By signing the SFDP application, the patient/responsible person authorizes the Center to confirm income and family/household size as disclosed on the application. Providing false information on a SFDP application will result in all SFDP discounts being revoked and the full balance of the account(s) restored and payable immediately.

Applicant Signature: _____	Date: _____
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INSTRUCTIONS- APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

The Rockbridge Area Health Center offers a Sliding Fee Discount Program (SFDP) to insured, uninsured and underinsured patients based on annual income and family size under the U.S. Department of Health and Human Services annual Federal Poverty guidelines. RAHC does not discriminate with regard to race, color, religion, national origin, age, gender, sexual orientation or disability. No one will be denied access to services due to inability to pay.

Please fill out the application completely and submit proof of household income along with the completed application. The patient/responsible person must complete the SFDP application in its entirety. Incomplete applications and applications missing income documentation will be returned and significantly delay processing. Patient eligibility for the SFDP is renewed at least once a year and every 6 months for patients with no income.

INCOME:

Income and required proof are defined as:

*Wages, salaries and tips:

- **One month's worth of pay stubs** that show gross amount (before taxes are taken out)
- RAHC Income Verification Statement to be completed by the employer
- Prior year's Federal Income Tax return (IRS 1040)

*Self-Employment income: Prior year's Federal Income Tax return (IRS 1040) to determine net income

*Unemployment compensation: Determination letter

*Social Security Benefits: **Current year** awards letter listing monthly amount before deductions

*Alimony: Legal proof or official awards letter

*Retirement or pension income, including IRA or 401k withdrawals: Bank statements

*Investment income, like dividends or interest: Monthly statement or awards letter

*Workers compensation: Determination letter

*Rental income: copy of a lease or rental payment

*Other taxable income such as prizes, awards and gambling winnings

If no income: a RAHC Statement of Support form must be signed by the patient and the person providing financial support

We count the following for enabling services only: child support, earned income from minor children, Supplemental Security Income, Supplemental Nutrition Assistance Program (SNAP) benefits, Veteran's Disability payments or proceeds from loans (student loans, home equity loans or bank loans)

HOUSEHOLD

Household is defined as: One person or a group of two people or more related by birth, legal marriage/partnership, or adoption and residing together. This excludes persons who may live under the same roof but who do not depend on the patient financially or do not support the patient financially such as roommates or other non-relatives.

Other Adults in home: If you are a spouse in the home, proof of your income is also required. Dependent adult children must provide proof of dependence (IRS 1040).

Comments: Please use this area to explain any unusual circumstances which you feel may be helpful: