Rockbridge Area Health Center

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

Full Name: _____ **Social Security Number:** _____

Name of Patient (If different from above): _____ **DOB:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Telephone: _____

Marital Status ❒ **Single** ❒ **Married** ❒ **Divorced** ❒ **Widowed** ❒ **Separated** ❒ **Common Law Marriage**

List of Household Members: (Include yourself)	Date Of Birth:	Relation To you:	Insured?	Income Type: Job, unemployment, Social Security, etc	Monthly Income: (before taxes)
		Self			
					Monthly Total:

Employer: _____ **Paid How Often?** _____ **Start date:** _____

Spouse's employer: _____ **Paid How Often?** _____ **Start date:** _____

If unemployed, date of last paycheck: _____

Please list the amount you receive monthly below:

SNAP Amount $_____ **Child Support $**_____ **SSI $**_____ **Veteran's Benefits $**_____ **Other** _____

By signing below, you give us the right to check your income and household size. If you give false information on this form, your discount will be stopped, and you will have to pay the full balance.

Sign:	Date:

25 Northridge Lane • Lexington, VA 24450
(540) 464-8700 • www.rockahc.org • *fax*: (855) 806-0826

Modified October 2023

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INSTRUCTIONS

Please fill out the whole form. You will need to turn in proof of household income and size.

INCOME:

- Pay stubs from the last 30 days or copy of tax return
- Self-Employment
- Unemployment
- Social Security
- Alimony
- Retirement or pension, including IRA or 401k withdrawals.
- Investment income
- Workers' compensation
- Rental income
- Other taxable income, such as lottery winnings

Please call us if you have no income or do not receive pay stubs.

HOUSEHOLD:

A household is you, your spouse, and any children or relatives you claim on your taxes.

Do not include roommates, friends, or anyone you would not claim on your taxes.

The Sliding Fee Discount is based on annual Federal Poverty guidelines.

We do not discriminate against race, color, religion, national origin, age, gender, sexual orientation, or disability.

No one will be denied medical services if they cannot pay.

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