Rockbridge Area
Health Center

INCOME VERIFICATION

This information is used for our Sliding Scale Financial Assistance Program

Name: _____ Date of Birth: _____

If you are unable to provide the required pay stubs, you must provide this completed and signed Income Verification form for each of your employers, even if you are paid in cash and do not include this income on your tax return.

Once we verify this information, you will be considered for the Sliding Scale Financial Assistance Program.

I give permission for Rockbridge Area Health Center to contact the person/business below to verify my employment:

Signature: _____ Date: _____

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This section must be completed by the Employer.

Name of Business: _____ Phone: _____

Contact Name: _____Address: _____

1. Date of Hire: ___/____/_____
2. Hourly Wage $_____ # of Hours/Week _____Tips: _____Commission: _____
3. How often does the employee get paid? BI-WEEKLY ____ MONTHLY ____
   WEEKLY _____

I understand Rockbridge Area Health Center may contact me to verify this information. I understand providing false information will result in the applicant's discount being revoked and the full balance being payable immediately.

Completed By (Print Name and Title): _____

Signature: _____ Date: _____

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