Sliding Scale Financial Assistance Program

STATEMENT OF SUPPORT

Anyone applying for Sliding Scale financial assistance with no income must complete this form.

You will need to reapply after six months.

Name: ______________________________________ DOB: _________________________________

Name of Spouse and/or Dependents:

I am not working and do not have income of any kind.

Sign: ______________________________________ Date: ________________

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To be completed by the person or organization giving help.

Name: ______________________________ Relationship: ___________________________________

Address: ___________________________ State: ___________ Zip Code: ______________________

Phone: ______________________________ Organization Name: ______________________________

Type of help given: (Please circle)

Cash Amount paid: _______ How Often: _________

Shelter Food Clothing Transportation

I confirm that the person above is not working, and I am helping them. I understand signing this form does **not** make me responsible for their bill. I understand giving false information will cause the discount to stop, and the person above will have to pay the full balance. I understand the Rockbridge Area Health Center may contact me.

Signature of person giving help: _________________________________ Date: ____________________