



**APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM**  
Proof of income is required to process this application

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

Does the patient have Insurance? (Please circle if YES)                      MEDICAL      DENTAL

If YES, please provide your insurance card to the front desk. If you do not have insurance, please call 540-464-8700 ext. 7150, 7117, or 7202 to discuss options with our Outreach & Enrollment Team

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			
					<b>Monthly Total:</b>

Monthly Housing Cost (rent/mortgage): \_\_\_\_\_

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 _____
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**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.**

<b>Sign:</b> _____	<b>Date:</b> _____
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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

**HOUSING COSTS:**

- Copy of Lease or rental agreement
- Copy of monthly mortgage statement

**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.**