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| **Alternative Proof of Income** |

**Please read the following:**

Valley Family Health Care (VFHC) offers a Sliding Fee Discount Program to help make health care more accessible and affordable. If you qualify, you can receive services at a lower cost.

To see if you qualify, we need to know:

* Your family size
* Your yearly income
* Proof of your income

You can show proof of income with any of the following:

* Paystubs
* Bank statements (last 90 days)
* Unemployment or employment verification from the state
* Last year’s tax return, if self-employed (Schedules C, E, or F)
* Social Security or Medicare disability letter
* A letter from your employer or someone you live with

**If you cannot reasonably provide proof of income, we have options.**

VFHC’s policy says no one will be denied care because they cannot pay or cannot provide proof of income. This form helps us determine if you can still qualify for a discount.

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| Name (please print): |  |
| **Please place a checkmark next to one of the below reasons:** |
|  | I have no source of income.  |
|  | I am unable to provide any of the standard forms of documented proof of income; this is my proof of income. |
| My gross annual income (before taxes) is: | $ |
| **Please read through the following statements, place a checkmark in each box, sign, and date below:** |
|  | **HEAD OF HOUSEHOLD ONLY:** I have filled out the Sliding Fee Discount application completely and to the best of my ability. |
|  | If I get standard proof of income later, I will give it to VFHC so they can review and reevaluate any discounts I received before providing standard proof of income.  |
| Explanation (if necessary): |
| Signature:  |  | Date:  |  |
| Staff Name: (please print):  |  | Date: |  |
|  |
| **STAFF USE ONLY** |
| If this form is for someone other than the Head of Household, please fill out the section below:  |
| **Sliding Fee Application Head of Household Information:** |
| Name (please print):  |  | MRN: |  |
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