|  |
| --- |
| **sliding fee scale application** |

Valley Family Health Care patients may qualify for a *discount* on their health care, even if they have insurance.

Please complete this form if you would like to apply for our Sliding Fee Scale.

* This form is effective on the date it is signed by the applicant and turned into VFHC staff; any services provided before this date are not covered.
* Proof of income is required to be turned in within 90 days of the effective date of this application from all household members who receive income. Discounts will not be applied until proof of income is received.
* You must reapply for a Sliding Fee Discount annually, OR when there is a change in income, insurance, or family size.
* Only one Sliding Fee Application is required per family.

|  |
| --- |
| **Responsible Party (Head of Household) Information:** |
| First Name: |  | Last Name: |  |
| Phone #:  |  | DOB:  |  |
| Address: |  |
| City: |  | State:  |  | Zip:  |  |
| Please list each family member who lives in your household. A family is a group of two or more persons related by birth, marriage, or adoption who live together. All such related persons are considered members of one family. Use the second page for additional household members. **There are \_\_\_\_\_\_\_\_\_ members in my household (include yourself).** |
| **Family Members** |
| *Name* | *DOB* | *Relation* | *Notes* |
| #1 |  |  |  |  |
| #2 |  |  |  |  |
| #3 |  |  |  |  |
| #4 |  |  |  |  |
| #5 |  |  |  |  |
| #6 |  |  |  |  |
|  |
| **Proof of Income** |
| Valley Family Health Care **requires** proof of income (**most recent 30 days**) for all members of the household who receive income in the form of one of the following:

|  |  |
| --- | --- |
| Pay stub (current and consecutive for 30 days) | Profit or Loss From Business |
| Profit or Loss From Farming | Retirement Distributions or Pensions |
| Social Security or disability printout | Rental/Royalty Income |
| Statement of Support from others providing Support or a Letter from the patient’s employer | Letter from Court for Alimony or Child Support |
| Letter from Paying Agency or ACH Deposits from Bank Statement for:* Unemployment
* Worker’s Compensation
* Veteran’s Payments
* AFDC – Aid to Families with Dependent Children
* Stipends
 |

  |
| **Please list the sources of *gross* annual income (before taxes) for all household members.** |
| Income Source 1:  | Amt Paid:  | $ | * Hourly
 | * Weekly
 | * Every 2 Weeks
 | * Monthly
 | * Yearly
 | # of Hours per Week:  |  |
| Income Source 2:  | Amt Paid:  | $ | * Hourly
 | * Weekly
 | * Every 2 Weeks
 | * Monthly
 | * Yearly
 | # of Hours per Week:  |  |
| Income Source 3: | Amt Paid:  | $ | * Hourly
 | * Weekly
 | * Every 2 Weeks
 | * Monthly
 | * Yearly
 | # of Hours per Week: |  |
| Income Source 4: | Amt Paid:  | $ | * Hourly
 | * Weekly
 | * Every 2 Weeks
 | * Monthly
 | * Yearly
 | # of Hours per Week:  |  |
| Income Source 5: | Amt Paid:  | $ | * Hourly
 | * Weekly
 | * Every 2 Weeks
 | * Monthly
 | * Yearly
 | # of Hours per Week:  |  |
| Income Source 6: | Amt Paid:  | $ | * Hourly
 | * Weekly
 | * Every 2 Weeks
 | * Monthly
 | * Yearly
 | # of Hours per Week:  |  |
| Total Income from all Sources:  | $ |
| If you have **NO** source of income, please fill out our Alternative Proof of Income Form.  |
|  |
| **Please read through the following statements, place a checkmark in each box, and sign and date below.** |
|  | I certify that the information provided on this form is true, complete, and accurate. I will promptly notify Valley Family Health Care of changes in insurance, family income, and/or family size.  |
|  | I understand that Valley Family Health Care shares my Federal Poverty Level score with our Laboratory and Pharmacy partners so that I may receive a discount for their services.  |
|  | I understand that intentionally providing false information may exclude me from discounts at Valley Family Health Care and that I may be billed for any discounts I receive with false information. I also understand that my income verification may be audited for accuracy, and I agree to provide all records as requested. |
| **Responsible Party Signature:**  |  | **Date:** |  |
| If not Patient, Relationship to Patient:  |  |
| **Staff Name (please print):**  |  | **Date:** |  |

**Provide additional information on a separate sheet.**

|  |
| --- |
| STAFF USE ONLY :Place all patient MRN labels here |