Rockbridge Area
Health Center

INCOME VERIFICATION

(This information is required only to determine eligibility for our Sliding Fee Scale Discount Program)

APPLICANT SECTION- To be completed by applicant.

I hereby grant Rockbridge Area Health Center permission to disclose my income in order to determine eligibility for the Sliding Fee Discount Program (SFDP).

Applicant Name: _____
Signature: _____ Date: _____

Income Verification – Submitted when applicant is unable to provide required pay stubs or is paid in cash.

If an applicant is unable to provide required **pay stubs** (i.e., pay stubs are not available and/or applicant has started employment and pay stubs have not been yet received) the applicant must provide a completed and signed Income Verification form from **each** employer. Once verified, the applicant will be considered for eligibility determination for Sliding Fee Discount Program.

If an applicant is **paid cash** from one or more employer's (individuals, businesses and/or organization), or is **paid cash** from individuals, businesses and/or organization for casual labor, day labor and/or domestic service (e.g., gardening, landscaping, housekeeping, daycare, babysitting, etc.) and the cash paid is **not** included on the applicant's tax return, the applicant must provide a completed and signed Income Verification form from **each** employer and **each** non-employer (i.e., individuals, businesses and/or organization) for services. Once verified, the applicant will be considered for eligibility determination for Sliding Fee Discount Program.

EMPLOYER / NON-EMPLOYER - This section must be completed by the employer / non-employer.

_____ _____
Name (individual / business / organization) Address State Zip Code

_____ _____
Contact Name Contact Phone Number

1. Date of Hire: _____/_____/_____
2. Hourly Wage $_____ # of Hours/Week _____
3. How often does applicant get paid? WEEKLY _____ BI-WEEKLY _____ MONTHLY _____

I understand Rockbridge Area Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the applicant's eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately.

Completed By (Printed Name and Title): _____

Signature: _____ Date: _____

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