INSTRUCTIONS- SLIDING FEE DISCOUNT PROGRAM APPLICATION

The Rockbridge Area Health Center offers a Sliding Fee Discount Program (SFDP) to insured, uninsured and underinsured patients based on annual income and family size under the U.S. Department of Health and Human Services annual Federal Poverty guidelines. RAHC does not discriminate with regard to race, color, religion, national origin, age, gender, sexual orientation or disability. No one will be denied access to services due to inability to pay.

Please fill out the application completely and submit proof of household income along with the completed application. The patient/responsible person must complete the SFDP application in its entirety. Incomplete applications and applications missing income documentation will be returned and significantly delay processing. Patient eligibility for the SFDP is renewed at least once a year and every 6 months for patients with no income.

INCOME:
Income and required proof are defined as:
*Wages, salaries and tips:
- **One month's worth of pay stubs** that show gross amount (before taxes are taken out)
- RAHC Income Verification Statement to be completed by the employer
- Prior year's Federal Income Tax return (IRS 1040)

*Self-Employment income: Prior year's Federal Income Tax return (IRS 1040) to determine net income

*Unemployment compensation: Determination letter

*Social Security Benefits: **Current year** awards letter listing monthly amount

*Alimony: Legal proof or official awards letter

*Retirement or pension income, including IRA or 401k withdrawals: Bank statements

*Investment income, like dividends or interest: Monthly statement or awards letter

*Workers compensation: Determination letter

*Rental income: copy of a lease or rental payment

*Other taxable income such as prizes, awards and gambling winnings

If no income: a RAHC Statement of Support form must be signed by the patient and the person providing financial support

We count the following for enabling services only: child support, earned income from minor children, Supplemental Security Income, Supplemental Nutrition Assistance Program (SNAP) benefits, Veteran's Disability payments or proceeds from loans (student loans, home equity loans or bank loans)

HOUSEHOLD:
Household is defined as: One person or a group of two people or more related by birth, legal marriage/partnership, or adoption and residing together. This excludes persons who may live under the same roof but who do not depend on the patient financially or do not support the patient financially such as roommates or other non-relatives.

Other Adults in home: If you are a spouse in the home, proof of your income is also required. Please sign this application if you live in the home and wish to be considered for this program. Dependent adult children must provide PROOF of dependence IRS 1040)

Comments: Please use this area to explain any unusual circumstances which you feel may be helpful:

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

Legal Name: ____ **Birth Date:** __________________________

Social Security Number: ____________________________________

Mailing Address:____

City: __________________________________ State: ___________________ **Zip**: ___________________________

Physical Address (if different than mailing): ____

Email Address: ____

Telephone #: ____________________ ¨GYWbXUfm:_________________________ ¨**Work:** _____________________

List any full time students in the home: _____________________________________

"Family/Household" includes the applicant, spouse and dependents.
Please see the back of this form for the definition of family/household and the types of income that must be reported

List of Family/Household members: If more space is needed, attach a separate sheet	**Date Of Birth**	**Relation To Applicant**	**Insured Yes or No**	**List Income Type** Wages, unemployment, pension, Social Security, alimony, rental income, investment, other taxable income	**Amount Per Month ~~Before~~ Taxes** (self-employed net)
		Self			
					Monthly Total:

Number of people living in your household: _________

Applicant's employer: _______________________________Paid How Often? ________________ Start date:____________

Other household member's employer: ______________________Paid How Often? ______________ Start date: __________

If unemployed, date of last paycheck: ______________________

If your income is zero, the STATEMENT OF SUPPORT must completed by the person supporting you financially.

It does <u>not</u> count as income but please list the monthly amount you receive of:

SNAP Amt: ________Child Support/TANF ________Supplemental Security Income ________Veteran's Benefits ________

DECLARATION: By signing the SFDP application, the patient/responsible person authorizes the Center to confirm income and family/household size as disclosed on the application. Providing false information on a SFDP application will result in all SFDP discounts being revoked and the full balance of the account(s) restored and payable immediately.

Applicant Signature:	Date:
Other adult and/or Partner Signature:	Date:

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