

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 Sliding Fee Discount Program (SFDP).	permission to disclose m	y income in orde	er to determine el	igibility for the
Applicant Name:Signature:	Date	e:	_	
Income Verification – Submitted when applic	ant is unable to provide r	equired pay stub	os or is paid in cas	sh.
If an applicant is unable to provide required employment and pay stubs have not been your Verification form from each employer. Once Sliding Fee Discount Program.	et received) the applicar	nt must provide	a completed an	d signed Income
If an applicant is paid cash from one or more from individuals, businesses and/or organizat landscaping, housekeeping, daycare, babysittin applicant must provide a completed and signe (i.e., individuals, businesses and/or organizate eligibility determination for Sliding Fee Discounts	tion for casual labor, daing, etc.) and the cash paided Income Verification for the tion) for services. Once	y labor and/or od is not include form from each	domestic service d on the applican employer and ea	(e.g., gardening, t's tax return, the ch non-employer
EMPLOYER / NON-EMPLOYER - This	s section must be complete	ted by the emplo	oyer / non-employ	er.
Name (individual / business / organization)	Address		State	Zip Code
Contact Name	Contact Phone Number		-	
1. Date of Hire:/				
2. Hourly Wage \$ # o	of Hours/Week	Tips:	Commission	:
3. How often does applicant get paid?	WEEKLY	BI-WEEKLY	Y MONT	THLY
I understand Rockbridge Area Health Center many providing false information or information sub SFDP discounts to be revoked and the full balance.	sequently determined to l	be false will resu	alt in the applicant	
Completed By (Printed Name and Title):				
Signature:		Date: _		