Sliding Fee Discount Program Application

VHC will serve all patients regardless of inablility to pay. As an FQHC, VHC will not discriminate based on race, color, sex, national origin, disability, religion, sexual orientation, or inability to pay. VHC accepts insurance including Medicaid, Medicare, CHIP, and most private plans.

Patient Information

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____ Phone#: _____

Employer Name: _____ **Household Size:** _____
(the number of people living in your home)

Applicant/Household Member Income Information

Name	Date of Birth	Relation to Applicant	Monthly Income	Income Source
		Applicant	$	
			$	
			$	
			$	
			$	

Household Income

Please provide proof of income for the last 30 days. Acceptable proof of income includes, but is not limited to, pay stubs, Social Security benefits, VA benefits, pension, unemployment benefits, or the previous years income tax return, including the schedule C. If you have no source of household income during this time period please complete the Limited Income Statement below.

Limited Income Statement

For the purpose of applying for the the Sliding Fee Discount, I have not received any income for the last 30 days. Briefly explain how you have managed to pay for necessary living expenses such as shelter, food, and utilities: _____

_____

_____

_____

Medicaid Assistance Screening

Are any household members eligible for Medicare?	Yes or No
Are any household members receiving SSDI or SSI?	Yes or No
Does the patient have a mental/physical disability that prevents them from working more than 1 year?	Yes or No
Does your household have minor or dependent children?	Yes or No
Is anyone in the household pregnant?	Yes or No

If you answered "Yes" to any of the above, you may be asked to apply for publicly available insurance. The Patient Advocacy Officer at Valley Health Care may contact you if it is determined that this may be the best option for you.

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Insurance Information for Applicant and Household Members

Name of Insurance Company:

ID Number(s): _____ _____ _____

Effective Date(s): _____ _____ _____

Date Verified: _____ _____ _____

Please enclose a copy of all insurance cards for any insured family members. If you applied for, and were denied Medicaid, please enclose a copy of the Denial Letter that you received from the Department of Health and Human Resources.

Notice to Applicants

To be assessed for the Sliding Fee Discount Program, applicants must provide the Business Office with requested information as indicated on the application. The applicant may be asked to apply for publicly available insurance (Medicaid or CHIP) if it is deemed to be the most affordable option for the applicant or their household members.

Approved adjustments apply to all fees falling within the eligibility period, excluding vision supplies such as glasses and contact lenses. Other exclusions may apply.

I certify that all of the above statements are true and accurate to the best of my knowledge. Authorization is hereby given to Valley Health Care to verify in any manner it deems appropriate any items indicated on this statement If any information I have given proves to be untrue, I understand that Valley Health Care may re-evaluate my financial status and take whatever action becomes appropriate.

I also understand that if I am approved for the Sliding Fee Discount Program, that my Sliding Fee payment is due at the time of service. However, payment arrangements are availiable if you are unable to pay the entire fee.

Applicants Signature:_____ Date:_____

Co-Applicants Signature:_____ Date: _____

Office Use Only

Verification of Proof of Income: _____Application
_____Tax Forms/Check Stub
_____Limited Income Statement (if applicable)

Total Household Income: 30 Days $_____ 12 Months: $_____

Program Qualified for: Nominal Fee 20% 40% 60% 80%

Patient Representative Signature: _____Date:_____

Supervisor's Approval:_____Date:_____

Office Use Only

Audited by: _____ Date: _____

_____ Application Complete

_____ Proof of Income