Shenandoah Community Health Sliding Fee Application

Name:	Social Security #	Date of Birth
Current address:		Phone:
City:	State:	Zip Code:
(*Please circle*) US Resident YES/NO	Veteran YES/NO	Migrant YES/NO
What office are you applying for? *(Please circle)*	Medical Dental Behavioral Health Winchester Office	
What type of insurance do you have? *(Please circle)*	Medicaid Medicare Commercial(BCBS, Aetna, Cigna) Other None	

EMPLOYMENT INFORMATION

Current employer:		How long?
Phone:	Hourly rate	Paid weekly bi-weekly *(Please circle)*
How many people are supported by this income (including you)?	How many hours per week do you work?	

SPOUSE/OTHER EMPLOYMENT INFORMATION

Current employer:		How long?
Phone:	Hourly rate	Paid weekly bi-weekly *(Please circle)*

LIST ALL HOUSEHOLD MEMBERS

PLEASE INDICATE WHICH MEMBER IS A DEPENDENT (A DEPENDENT IS DEFINED AS SOMEONE WHO IS LISTED ON YOUR FEDERAL INCOME TAX FORM) PROVIDE ***SEPARATE SHEET IF MORE ROOM IS NEEDED***

Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:

LIST ALL FORMS OF INCOME ***PROVIDE PROOF OF INCOME***

Public Assistance $ *(cash benefits)*	Social Security/ Disability $	Pensions/Retirement $
Alimony $	Child Support $	Unemployment $

You must attach proof of income for every person receiving income who resides in your household. If you have no income to report, please contact our office for further instruction at 304-596-2215 or email slidingfee@svms.net.

Continued on reverse side

I swear and affirm under penalty of perjury, that all the information listed is accurate to the best of my knowledge. I have received the sliding fee pamphlet and understand my responsibility as a sliding fee participant. Your financial information is not forwarded to any agency. Your payment is due at time of visit. Discounted services may be backdated up to 90 days from the application approval date.

Patient/Parent/Legal Guardian Signature Date

Other Household members applying for the Sliding Fee Program:

Print Name	Date of Birth	Signature	Date
Print Name	Date of Birth	Signature	Date
Print Name	Date of Birth	Signature	Date
Print Name	Date of Birth	Signature	Date

Please provide any additional information that will assist us with the application process.

FOR OFFICE USE ONLY

Received by_____ Date:_____

Calculated by_____ Date:_____

Approved by_____Date:_____ Expiration Date:_____

Discount Percent_____% EHR Review Medical_____ BHS_____

Shenandoah Valley Medical System, Inc. does business as Shenandoah Community Health (SCH). This health center receives Health and Human Services funding and has Federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. SCH is an equal opportunity provider, serving all patients regardless of ability to pay.