

Shenandoah Community Health Sliding Fee Application

Name:		Social Security #		Date of Birth	
Current address:				Phone:	
City:		State:		Zip Code:	
<i>(Please circle)</i> US Resident YES/NO		Veteran YES/NO		Migrant YES/NO	
What office are you applying for? <i>(Please circle)</i>		Medical	Behavioral Health	Dental	Winchester Office
What type of insurance do you have? <i>(Please circle)</i>		Medicaid	Medicare	Commercial(BCBS, Aetna, Cigna)	Other None
EMPLOYMENT INFORMATION					
Current employer:				How long?	
Phone:		Hourly rate		Paid weekly bi-weekly <i>(Please circle)</i>	
How many people are supported by this income (including you)?			Are you a full time student?		
SPOUSE/OTHER EMPLOYMENT INFORMATION					
Current employer:				How long?	
Phone:		Hourly rate		Paid weekly bi-weekly <i>(Please circle)</i>	
LIST ALL HOUSEHOLD MEMBERS					
<i>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</i>					
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 <i>PROVIDE PROOF OF INCOME</i>					
Public Assistance \$ <i>(cash benefits)</i>		Social Security/ Disability \$		Inheritance \$	
Alimony/Child Support/TANIF \$		Pensions/Retirement \$		Unemployment \$	

You must attach proof of income for every person receiving income who resides in your household. If you have no income to report we will need to request additional information, please contact our office prior to completing your application. For assistance or questions, please contact our office 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. Sliding Fee does not go into effect until the application has been approved.*

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

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

FOR OFFICE USE ONLY

Calculated by _____ Date: _____

Approved by _____ Date: _____ Expiration Date: _____

Discount amount _____ % Denied _____



Shenandoah Valley Medical System, Inc. does business as Shenandoah Community Health.

This health center is a Health Center Program grantee under 42 USC 254b, and a deemed Public Health Service employee under 42 USC 233(g)-(n)