

Southwest Virginia Community Health Systems, Inc.

P.O. Box 729, Saltville, Virginia 24370/Phone (276)496-4492

Application for Reduced Fee Status

Head of Household's Name		Social Security #
Spouse's Name		Social Security #
Mailing Address		Phone#
Employer Name/Address/Phone	Spouse Employer Name/Address/Phone	
Additional Members of Household		
Name/Date of Birth		Name/Date of Birth
Name/Date of Birth		Total # in Household

Statement of Understanding

The information I have provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay for purpose of procuring for my own and my family's benefit the discount of my accounts with Southwest Virginia Community Health Systems, Inc. (SVCHS). I understand that SVCHS will rely on such information to determine applicable discount rate for my account.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Virginia.

I agree to report any change in either my income or my family size to SVCHS before or at the time of my next contact or any contact by any family member with SVCHS. I know that the information I have given will continue to be relied upon until it is changed.

I understand that my discount status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If SVCHS has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, SVCHS may initiate a review of my status. I hereby authorize the investigation of all statements contained herein and authorize the release of all employment records, bank record, and other financial information to an agent of Southwest Virginia Community Health Systems, Inc.

My signature below indicates that all information I have provided is true to the best of my knowledge.

Head of Household Signature	Date	Spouse Signature	Date
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Family Income Determination Worksheet (please indicate amount and frequency of pay)

Wages	Disability Income	Welfare Payments	Veteran's Benefits
Personal Business Profits	Unemployment Benefits	Aid to Dependent Child	Other (please specify)
Farm Income	Social Security Benefits	Alimony	Other (please specify)
Seasonal Income	Pensions/Annuities	Child Support	Total Annual Gross Income

Office Use Only

Applicant	Date Rec'd
Acct(s)	Site
	BC
	FS
	AGI
Reduced Fee Status	Expiration Date
Authorized Signature	

Bank Clearance

Applicant Use

I, _____, hereby authorize representatives of Southwest Virginia Community Health Systems, Inc. to be given any information requested concerning my account(s).

Name of Financial Institution	Account Number
Address of Financial Institution	Social Security Number
	Signature

SVCHS Use Only

The above signatory has applied to our organization for assistance under the terms of the sliding fee scale as amended and has given permission for clearance at your institution. Please provide the following information on all accounts.

Financial Institution	Date	Authorized Signature
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Bank Use Only

Present Balance

Checking	Safety Deposit Box <input type="checkbox"/> yes <input type="checkbox"/> no
Savings	Restricted Balance <input type="checkbox"/> yes <input type="checkbox"/> no
CDs	Trust Fund <input type="checkbox"/> yes <input type="checkbox"/> no
	Other Assets <input type="checkbox"/> yes <input type="checkbox"/> no

Recent Deposits

Recent Withdrawals

Date/Amount	Date/Amount
Date/Amount	Date/Amount
Date/Amount	Date/Amount
Date/Amount	Date/Amount

Description and Amount of Outstanding Loans/Liabilities:

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Date	Authorized Signature of Bank Official
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Proof of Income

Proof of household income includes:

1. A copy of the previous year's tax return or W-2 form.
2. Check stubs from your current job or a letter from your employer stating gross earnings.
3. Proof of social security, food stamps, or other public assistance.
4. Proof of child or spousal support.

Proof Of No Income

If you currently have no household income please include one of the following:

1. Statement from Virginia Employment Commission approving or denying unemployment compensation. Review the situation in ninety days or at next clinic visit, whichever comes first. If unemployment compensation is denied, proof of how patient is supporting themselves. We must have a statement from the person providing lodging and food for the patient.
2. Termination notice from previous employer.
3. Layoff notice from previous employer.
4. Statement from person supplying food and shelter.
5. If no income at time of financial eligibility screening, family will be designated as income A, and financial screening is to be done again in ninety (90) days or at next clinic visit, whichever comes first. Explain in "Remarks" how family is supporting itself, e.g. savings, loans, etc.
6. Proof of Medicaid or welfare cancellation.

Other Income

Unusual situations not previously described should be fully explained in the "Remarks" section below.

Remarks

Reduced fee status cannot be determined until the completed application is returned.

Signature: _____

Printed Name: _____

Date: _____