ATTENTION

SLIDE-FEE APPLICANTS

YOUR COPAY IS DUE ON DATE OF SERVICE. THE STATUS OF YOUR SLIDING FEE WILL BE DETERMINED AFTER THE APPLICATION IS PROCESSED AND YOU WILL BE NOTIFIED BY MAIL. YOUR FINAL BILL IS DEPENDANT ON THE SLIDE FEE LEVEL YOU QUALIFY FOR AND MAY BE MORE THAN THE COPAY ON THE DATE OF SERVICE.

PROOF OF INCOME AND A COPY OF YOUR MOST RECENT BANK STATEMENT MUST BE ATTACHED BEFORE THE APPLICATION WILL BE PROCESSED.

IT IS **VERY IMPORTANT** THAT YOU RETURN THE APPLICATION IN **10 DAYS OR LESS.**

***IF YOU DO NOT RETURN YOUR SLIDE FEE APPLICATION BY YOUR NEXT VISIT OR 10 DAYS FROM TODAY PLEASE BE PREPARED TO PAY ALL CHARGES FOR YOUR VISITS ***

Southwest Virginia Community Health Systems, Inc.

PO Box 729 Saltville, VA 24370 Phone (276)496-4492 Fax (276)496-4839

Application for Reduced Fee Status

Applicant's Name	Social Security #	Date of Birth
Spouse's Name	Social Security #	Date of Birth
Mailing Address		Email Address
City, State, Zip		Phone#
Employer Name/Address/Phone	Spouse Employer Name/Address/Phone	
Additional Members of Household		
Name/Relation/Date of Birth	Name/Relation/Date of Birth	
Name/Relation/Date of Birth	Name/Relation/Date of Birth	
Name/Relation/Date of Birth	Name/Relation/Date of Birth	
	Total # in Household	

Family Income Determination Worksheet (please indicate amount and frequency of pay)

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

***Provide copy of MOST RECENT bank statement**

Office Use Only

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

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The following items are required before the application can be processed.

Proof of Income

Proof of household income includes at least one of the following:

1. A copy of the previous year's tax return or W-2 forms.
2. Check stubs from your current job or a letter from your employer stating gross earnings.
3. Proof of social security income, food stamps, or other public assistance.
4. Proof of child or spousal support.
5. **Copy of most recent bank statement (required). If no bank account, please indicate NONE.**

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.
2. Termination notice from previous employer.
3. Layoff notice from previous employer.
4. Statement from person supplying food and shelter.
5. Proof of Medicaid or welfare cancellation.
6. If there is no income at the time of financial eligibility screening, the family will be designated as Slide Fee A, and financial screening will be reviewed in ninety (90) days. Explain below in "Remarks" how family is supported financially, e.g. savings, loans, etc.

Other Income

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

Remarks

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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 an 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.

Applicant Signature **Date**

Spouse Signature **Date**