Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Account Number:

CLINCH RIVER HEALTH SERVICES, INC.
17633/17285 VETERANS MEMORIAL HWY.
DUNGANNON, VA 24245

THIS FORM AND INCOME MUST BE RETURNED WITHIN 30 DAYS OF VISIT FOR DISCOUNT TO APPLY IF YOU ARE DETERMINED TO BE ELIGIBLE.

APPLICATIONS WITHOUT INCOME OR INCOME WITHOUT AN APPLICATION WILL BE DESTROYED AFTER 30 DAYS.

Sliding Fee Eligibility Form for Uninsured and Insured Patients

It is necessary for us to ask personal questions in order to give you a discount on your medical expenses. This information will be kept on file in our clinic in strict confidence. You must verify your household income at least every 12 months. Your annual income tax return with a copy of your W-2 forms, payroll check stubs, your social security benefit Letters, retirement benefit letters, or copies of other checks you may receive can be used as proof. Your annual household income and family size will be used to calculate the level of discount you are eligible for.

Today's Date: _____ Number of people living in your home? _____

What is your marital status? ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

Do you own or rent your home? ☐ Own ☐ Rent ☐ Live with Someone

Amount of Annual Household Income?

You	Your Spouse	Your Children	Other Person	Total Monthly Inc.

Place of Employment?

You	Your Spouse	Your Children	Other Person

Do you have money in your savings account? $ _____

Do you have money in a checking account? $ _____

Do you have any rental property, stock or certificates? Yes ☐ No ☐

Do you or a family member have insurance? Ins Co: _____ Yes ☐ No ☐

Do you receive any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

Please list all members in your household as stated above and if they are to be covered by this application.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

I declare the above information is true, and I give Clinch River Health Services, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence**. I also understand that if my income should change that I am required to notify the receptionist on my next visit. Signature: _____**

Approved By: _____ Income Code: _____ Expiration Date: _____

If you have participated in the Sliding Fee Program in the past, does the Nominal Fee that you have paid seem nominal or acceptable to you?

Yes _____ No _____