

## Sliding Fee Scale

VPCHC is a Federally Qualified Health Center that receives government funding. Due to this funding, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and/or your family, please complete the information below and provide verification of income within 10 days of receipt of this application. Should the required documentation not be received, no discount will be given.

### Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work or Cell phone: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

### Household Information: List all individuals living in the home.

Name	Date of Birth
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

**Income Information:** Please complete for all adult household members who are employed.  
Proof of income (income tax return or last 2 paystubs) must be provided.

Employed person: \_\_\_\_\_ Company: \_\_\_\_\_

Income (before taxes) \$ \_\_\_\_\_ Paid: ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other

Employed person: \_\_\_\_\_ Company: \_\_\_\_\_

Income (before taxes) \$ \_\_\_\_\_ Paid: ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other

### Other Income:

Alimony \$ \_\_\_\_\_ Child support \$ \_\_\_\_\_ Disability \$ \_\_\_\_\_ Pension \$ \_\_\_\_\_

Social security \$ \_\_\_\_\_ S.S.I. \$ \_\_\_\_\_ Unemployment \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

*By signing below, I agree to provide VPCHC with proof of income for the purpose of calculating my discount. I understand I will be asked to reapply on an annual basis and agree to inform VPCHC if there are changes to my income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of service. I hereby certify that the information provided is correct.*

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

### For Office Use Only

Account # \_\_\_\_\_

Effective date \_\_\_\_\_

Total income \$ \_\_\_\_\_

Discount \_\_\_\_\_

Staff initials \_\_\_\_\_

## Required Documentation

The following documentation is needed to complete your sliding fee application. Please provide all documentation which applies to your household.

\_\_\_\_\_ Pay stubs (most recent 30 days)

\_\_\_\_\_ W2's or a copy of your most recent tax filing with the IRS

\_\_\_\_\_ 4506-T form if you have not filed taxes in the last year

\_\_\_\_\_ Letter from the person you are living with who is providing food and shelter.  
The letter must be signed and dated.

\_\_\_\_\_ Copy of your unemployment statement, social security benefits deposit (or benefit statement) or any other type of direct deposit income.

\_\_\_\_\_ Proof of residency (any piece of mail received at your current address)

In order to complete your sliding fee application, all documentation should be received within 10 business days. Due date \_\_\_\_\_

Your prompt attention to this matter will ensure all eligible discounts are received.