**RVPCS SLIDING FEE DISCOUNT PROGRAM APPLICATION** **DATE: ______________________**

**LAST NAME: _____________________________** **FIRST NAME: ________________________________**

**DATE OF BIRTH: _______________________** **SSN: ______________________** **□ IF N/A**

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The RVPCS Sliding Fee Discount Program is for all **RVPCS patients**. Eligibility is determined by the number of persons living in the family/household and total annual income of individuals in the family/household. An updated application must be completed every 12 months to remain eligible.

The application with all required documentation must be completed and approved before this discount can be applied. **Any charges incurred prior to approval date will be the responsibility of the patient and are payable on the date of service. The applicant is aware that false or misleading statements will disqualify him/her from the program**

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Section 1: This application requires the patient report their household size and income. To complete your application, please provide the following documentation:

***Proof of Income*** to calculate gross annual income. Accepted forms of income verification includes:

□ Paystubs
□ Social Security
□ Disability
□ Unemployment
□ Federal/State Income Tax Form
□ Bank Statement
□ Wages and Tax statement (W-2)
□ No income: C*omplete the following if applicable in section 2:* □*Support Verification* □ *Attestation of No Income*

**Total Number of People in Household: ______________________**

*Total household includes any immediate family members living in the home (i.e. mother/father/children) and any person that lives in the home and mutually contributes to household expenses.*

**Total Annual Income: $______________________**

*Total income includes employment wages, social security benefits, unemployment benefits, disability benefits, alimony/child support, and pension.*

_________________________________________ _____________________________

Applicant Signature Date

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Section 2: Complete the following if you answered ***NO INCOME***

**SUPPORT VERIFICATION**

I, ______________________________ verify I provide in-kind assistance or cash assistance/payments to_____________________________. To my knowledge he/she has no income from any other source.

SIGNATURE (of supporter)___________________________ DATE ________________

_________________________________________ _____________________________

ADDRESS/CITY/STATE (of supporter) TELEPHONE

**ATTESTATION FORM OF NO INCOME**

I, __________________________________________, am currently unemployed. I have no income at this time.

I do not have any income from any source including Social Security, Disability, Unemployment, Child Support, Spousal Support/Alimony, Retirement/Pension/VA, Welfare, or from the Department of Human Services for myself or dependent household members.

I will inform River Valley Primary Care Services of changes in my employment status and provide proof of income to support my application for assistance through the Sliding Fee Discount Program. I understand that misleading or false statements will prevent me from participating in this program.

_________________________________________ _____________________________

Applicant Signature Date

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*Office Use Only: Reviewed/Entered by: _________________________ Approval dates ___________ to ___________*

*Qualified for: Slide [A] $20, $0, 50% [B] $25, $5, 40% [C] $35, $8, 35% [D] $45, $10, 30% [E] $50, $12, 25%*