

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 yearly income tax return with a copy of your W-2 form, payroll check stubs, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

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 Monthly Family 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 any rental property, stock or certificates? Yes  No

Do you have money in a checking account? \$ \_\_\_\_\_ Do you or a family member have insurance? Yes  No  Ins Co: \_\_\_\_\_

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.

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:** \_\_\_\_\_

**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 \_\_\_\_\_