SCH
Shenandoah
Community Health

Listed below are the documents requested for income verification for the Sliding Fee Program. Please complete and return the sliding fee application with proof of income that is most applicable to your current income status. A green return mail envelope has been included for your convenience.

The sliding fee program is not considered Insurance/healthcare coverage. The sliding fee program provides approved patients a reduced fee for services received at offices throughout Shenandoah Community Health. All uninsured patients can speak with our ACA staff located at 99 Tavern Road, Martinsburg in reference to obtaining healthcare coverage, visit www.healthcare.gov or call 1-800-318-2596.

Please be sure that all sections of application are completed. For questions or assistance, please call Shenandoah Community Health at 304-596-2215 or email slidingfee@svms.net.

Employment (Proof of one is required)	• 1 month of most recent paystubs • Most recent year tax return (W2 Form Not Accepted) • Letter from employer stating gross wages on letter head or notarized letter
Self-Employment	• Most recent year tax return with schedule C
Unemployment/Workman's Compensation	• Official benefit letter stating weekly/monthly amount
Disability/Social Security	• Most recent Official Medicare benefit letter for current year (1099 Form Not Accepted)
Child Support/Alimony	• Official letter or court order
Government Assistance	• Official benefit letter
Pensions	• Official benefit letter
If claimed on someone else's tax return:	• Most recent year tax return is required
No Income	• Call office for financial certification form

Shenandoah Community Health

Sliding Fee Discount Program Survey

Patient Name: _____ **Date of Birth:**_____

Family Size	up to 100%	101 - 125%	126 - 150%	151 - 175%	176 - 200%	201 % above
DOLLAR AMOUNT OF CHARGES THAT THE PATIENT PAYS						
Nominal Payment Medical	$20.00	$35.00	$65.00	$95.00	$115.00	n/a
Nominal Payment Dental	$25.00	$40.00	$70.00	$100.00	$120.00	n/a
Nominal Payment OB Delivery	$250.00	$400.00	$600.00	$800.00	$1,000.00	n/a
Nominal Payment Laboratory	$15.00	$20.00	$25.00	$30.00	$35.00	n/a

1. **Is the minimal nominal fee affordable for your medical services?** **Yes** **No**

_____

_____

2. **Is the minimal nominal fee affordable for your dental services?** **Yes** **No**

_____

_____

3. **Is the minimal nominal fee affordable for your laboratory services?** **Yes** **No**

_____

_____

4. **Is the minimal nominal fee affordable for your OB delivery services?** **Yes** **No**

_____

_____

Patient Signature: _____ **Todays Date:**_____

Shenandoah Community Health Sliding Fee Application

Name:	Social Security #	Date of Birth
Current address:		Phone:
City:	State:	Zip Code:
(*Please circle*) US Resident YES/NO	Veteran YES/NO	Migrant YES/NO
What office are you applying for? (*Please circle*)	Medical Dental Behavioral Health Winchester Office	
What type of insurance do you have? (*Please circle*)	Medicaid Medicare Commercial (BCBS, Aetna, Cigna) Other None	

EMPLOYMENT INFORMATION		***PROVIDE PROOF OF INCOME***
Current employer:		How long?
Phone:	Hourly rate	Paid weekly bi-weekly (*Please circle*)
How many people are supported by this income (including you)?	How many hours per week do you work?	

SPOUSE/SIGNIFICANT OTHER/OTHER EMPLOYMENT INFORMATION		***PROVIDE PROOF OF INCOME***
Current employer:		How long?
Phone:	Hourly rate	Paid weekly bi-weekly (*Please circle*)

LIST ALL HOUSEHOLD MEMBERS

PLEASE INDICATE WHICH MEMBER IS A DEPENDENT (A DEPENDENT IS DEFINED AS SOMEONE WHO IS LISTED ON YOUR FEDERAL INCOME TAX FORM) PROVIDE ***SEPARATE SHEET IF MORE ROOM IS NEEDED***

Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:
Name	Relationship:	Date of birth:

LIST ALL FORMS OF INCOME		***PROVIDE PROOF OF INCOME***
Public Assistance $ (*cash benefits*)	Social Security/ Disability $	Pensions/Retirement $
Alimony $	Child Support $	Unemployment $

You must attach proof of ALL income for every person receiving income who resides in your household. If you have no income to report, please contact our office for further instruction at 304-596-2215 or email slidingfee@svms.net.

Continued on reverse side

I swear and affirm under penalty of perjury, that all the information listed is accurate to the best of my knowledge. I understand my responsibility as a sliding fee participant. Your financial information is not forwarded to any agency. Your payment is due at time of visit. Discounted services may be backdated up to 90 days from the application approval date.

Patient/Parent/Legal Guardian Signature Date

Other Household members applying for the Sliding Fee Program:

Print Name	Date of Birth	Signature	Date
Print Name	Date of Birth	Signature	Date
Print Name	Date of Birth	Signature	Date
Print Name	Date of Birth	Signature	Date

Please provide any additional information that will assist us with the application process.

FOR OFFICE USE ONLY

Received by_____ Date:_____

Calculated by_____ Date: _____

Approved by_____ Date: _____

Sliding Fee Policy Start Date: _____ Expiration Date: _____

Percentage of Federal Poverty Line_____% EHR Review Medical_____ Dental_____ BHS_____ Lab_____ OB/Delivery_____