APPLICATION FOR DISCOUNT SERVICES

Patient Name: _____Phone:_____

Please mark each statement that applies to you or a family member who is also on this application. <u>This information will not be used to withhold or deny services to you or your family.</u>

<u>I.SLIDING FEE SCHEDULE</u>

As a Federally Qualified Health Center, Blue Ridge Health offers a Sliding Fee discount program for those who qualify. **You may receive the discounted rate even if you have private insurance**, Marketplace insurance, or Medicare, if the discounted rate is lower than your normal out-of-pocket cost. If you are not eligible for the sliding scale, choose not to apply, or do not provide household and income information, you will be expected to pay the full charge for care.

<u>II. ELIGIBILITY VERIFICATION</u>:

How many people live in your household? _____

Gross income: Please list your household's gross income (the $ amount received before taxes are taken out). Household income includes *everyone* in the home.

Combined gross income: _____ Frequency: _____

<u>How are you providing proof of income?</u>

- ☐ Check Stubs
- ☐ W-2
- ☐ Letter of Support
- ☐ Self-Declaration
- ☐ Social Security Statement

Consent for Application for Discount Services

I understand that this information is to be used to determine eligibly for the Blue Ridge Health Sliding Fee Discount Schedule. I understand that Blue Ridge Health official may verify information on this form. I understand that the application will only be valid for 6 months unless proof of income was provided, self-declaration can only be approved once every 12 months. I certify that the information provided above is accurate and complete to the best of my knowledge. In the event of a change in income or insurance coverage, I will notify Blue Ridge Health at my next appointment. I understand that **I will be financially responsible for all or a portion of my care** and that I will be **asked to submit payment at the time of service**. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled. I understand that Blue Ridge Health uses a system called Oasis Insight or an Electronic Health Record to help determine eligibility for sliding fee and other services and I consent to have the above information stored in those systems.

Patient Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Slide (A-E): _____