

Sliding Fee Scale Discount Program Application

How Does the Sliding Fee Scale Discount Program Work?

As a Federally Qualified Health Center (FQHC), Martinsville Henry County Coalition for Health and Wellness (MHC CHC), is required to provide a sliding fee scale discount program to patients who meet the eligibility guidelines. To determine if you are eligible for this discount, you will need to fill out & sign this application. The sliding fee scale discount application is used to determine eligibility for the sliding scale and to assess the level of discount assigned to the patient.

In addition to this application, you will need to provide MHC CHC with the following documents to apply for the Sliding Fee Scale Discount Program:

Proof of income for you and anyone who resides/lives in your home. The following items may be used as proof of income:

- W-2 forms
- Two most current pay stubs (Months' Worth of Income)
- Income Tax Returns
- Unemployment Benefits letter/Social Security Benefit Letter/Public Assistance Benefits Letter
- Self-Declaration of Income
- If you are not working, and do not have a source of income, a letter of support from someone who is supporting you financially or the individual that you are living with.

Proof of Identification will also be required to the form of any two of the following **VALID and CURRENT** documents:

- State Issued Driver's License
- State Issued ID Card
- Birth Certificate
- Marriage License (For name Verification Only)
- Employment ID Badge
- Virginia Medicaid Identification Card
- Utility Bill
- Valid Passport
- Alien Registration Card (Commonly Known as a "Green Card")

Patients will be granted a ONE visit exclusion from providing proof by providing self-attestation of income.

However, for any subsequent visit, without proof of income, the patient will be considered to fall within the "above 200% of the Federal Poverty Guidelines" and billed at 100% of the charge. The SFDS will be valid for one (1) year from the date proof of income is provided.

Patients will not be required to apply for insurance and be turned down as a prerequisite for eligibility for the SFDS.

Insured patients who are eligible for SFDS will be charged no more than the amount they would have owed under the SFDS based upon their pay class, subject to any contractual or other legal restrictions.

IF YOU DO NOT WISH TO APPLY FOR THE DISCOUNTED SLIDING FEE SCALE AT THIS TIME, PLEASE CHECK THE BOX BELOW:

I UNDERSTAND THAT I HAVE THE RIGHT TO DECLINE REDUCED FEE STATUS; HOWEVER, IF AT TIME MY FINANCIAL STATUS CHANGES, I CAN APPLY FOR REDUCED FEE STATUS AT THIS FACILITY.

Patient Information

Name (First) _____ (Last) _____ Date of Birth _____

If you are over 18, do you live in someone else’s home other than your family? Yes No

Are you currently employed? YES NO

Is your spouse/partner currently employed? YES NO N/A

Are any other family members, who live with you, employed? YES NO N/A

Household Members & Gross Income, (This includes all people claimed on taxes meaning your children, spouse/partner)

2026 Federal Poverty Guidelines																			
Medical/Primary Care																			
Family Size	Slide A		Slide B				Slide C				Slide D				FULL FEE				
	Nominal Fee \$15.00		Nominal Fee \$20.00				Nominal Fee \$30.00				Nominal Fee \$40.00				201% and Above FPG				
	0-100% FPG		101%-150% FPG				151%-174% FPG				175%-200% FPG								
	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	
1	1,330	15,960.00	1,343	1,995	15,961	23,940	2,015	2,314	23,941	27,770	2,314	2,660	27,771	31,920	2,314	2,673	27,772	32,080	
2	1,803	21,640.00	1,821	2,705	21,641	32,460	2,732	3,138	32,461	37,654	3,138	3,607	37,655	43,280	3,138	3,625	37,656	43,496	
3	2,277	27,320.00	2,299	3,415	27,321	40,980	3,449	3,961	40,981	47,537	3,961	4,553	47,538	54,640	3,962	4,576	47,539	54,913	
4	2,750	33,000.00	2,778	4,125	33,001	49,500	4,166	4,785	49,501	57,420	4,785	5,500	57,421	66,000	4,785	5,528	57,422	66,330	
5	3,223	38,680.00	3,256	4,835	38,681	58,020	4,883	5,609	58,021	67,303	5,609	6,447	67,304	77,360	5,609	6,479	67,305	77,747	
6	3,697	44,360.00	3,734	5,545	44,361	66,540	5,600	6,432	66,541	77,186	6,432	7,393	77,187	88,720	6,432	7,430	77,188	89,164	
7	4,170	50,040.00	4,212	6,255	50,041	75,060	6,318	7,256	75,061	87,070	7,256	8,340	87,071	100,080	7,256	8,382	87,072	100,580	
8	4,643	55,720.00	4,690	6,965	55,721	83,580	7,035	8,079	83,581	96,953	8,079	9,287	96,954	111,440	8,080	9,333	96,955	111,997	

Household Member Name	Relationship to Patient	Date of Birth	Monthly Income (Gross)	Insured? (Yes/No)	Student? (Yes/No)
1.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
2.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
3.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
4.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
5.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
6.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
7.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				
8.	<input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other Dependent				

**** Proper proof of income documents must be provided for each household member**

Patients will not be refused treatment due to their inability to pay. Patients who are unable to pay their fees incurred for services or items received may apply for Budget Plan/Pay Agreement or speak with an MHC CHC representative about requesting a hardship determination to waive or reduce fees. If a patient refuses to pay the balance of their bill, refuses to work with a financial counselor to assist them in the payment of their bill, is sent to collections by MCHC but nevertheless continues to refuse to make payment thereon without requesting a hardship waiver, or is denied a hardship waiver by MCHC, then MCHC reserves the right to start the dismissal process of the patient from its services, through consultation with patient's provider and MHC CHC's legal counsel.

Statement of Understanding:

The information provided about family size and gross annual income from all sources is true, accurate and complete to the best of my knowledge. Information concerning my financial situation, means and ability to pay is given for the purpose of obtaining a discount on my accounts with Bassett Family Practice (BFP or RFH) or Ridgeway Family Health (RFH) for my own and my family's benefit. I understand BFP or RFH will rely on such information to determine applicable discount rates for my account. I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the Commonwealth of Virginia.

I agree to report any change(s) in either my income or family size to BFP or RFH before or at my next contact or any contact by any family member with BFP or RFH. I know that the information I have given will continue to be relied upon until it is changed. I understand that my discount status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If BFP or RFH has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, BFP or RFH may initiate a review of my status. I hereby information to an agent of BFP or RFH.

APPLICATION MUST BE ACCOMPANIED BY PROOF OF FINANCIAL SITUATION BEFORE DISCOUNT WILL BE APPLIED. PROOF OF INCOME MUST BE PROVIDED WITHIN THIRTY (30) DAYS OF THIS VISIT IN ORDER TO CONTINUE REDUCED FEES FOR OTHER VISITS. FAILURE TO PROVIDE VERIFICATION WILL RESULT IN LOSS OF REDUCED FEES AND YOU WILL BE CHARGED FULL PRICE FOR YOUR VISIT. My signature below indicates that all information I have provided is true to the best of my knowledge.

Signature _____

/Date _____

APPLICATION MUST BE RENEWED ANNUALLY WITH UPDATED PROOF OF INCOME

NO SLIDING SCALE AVAILABLE FOR FOLLOWING SERVICES

The sliding scale discount is not applied to the following services which arise at the request of employers or parties, other than the patient: **Virginia DOT Physicals**