Sliding Fee Program

The sliding fee program allows Tri-Area Community Health (TACH) patients who are uninsured or under-insured to receive healthcare services at a lower cost. We understand it’s not always possible for patients to be covered by health insurance, or that insurance may have high deductibles. TACH offers a sliding fee program to assist patients who may not qualify for public benefits and/or who are not able to afford the full cost of healthcare. An annual grant from the Department of Health & Human Services, Bureau of Primary Health Care provides the resources which enable us to assist patients who may not otherwise be able to afford their medical care and medications. The sliding fee program is offered at all three sites and applications are processed by staff at each site.

The sliding fee program only applies to services provided at the Tri-Area Community Health facilities. Medication discounts apply only to prescriptions written by TACH providers. Slide discounts cannot be used at other doctor offices, pharmacies or hospitals.

What services are offered?

- Medical
- X-ray
- Dental
- Laboratory
- Pharmaceutical
- Behavioral Health

What is required to apply?

- Complete registration packet
- Provide proof of household income or financial assistance
- Household is defined as the applicant + spouse/significant other + their legal tax dependents

How often do I need to apply?

Patients will need to apply for the sliding fee program at least every year. The discounts will typically last 3, 6, or 12 months depending on the patient’s unique financial situation. Patients renewing sliding scale eligibility will need to complete a new slide application packet and submit current proof of income before their discount expires. If the discount expires, the patient will have to pay the full charges until a new application packet is processed and approved.

Will I qualify?
See next page for income levels and fees.
### Tri-Area Community Health Sliding Fee Schedule of Discounts

Effective February 11, 2019

<table>
<thead>
<tr>
<th>Family Size</th>
<th>LEVEL A</th>
<th>LEVEL B</th>
<th>LEVEL C</th>
<th>LEVEL D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - 100% FPL</td>
<td>101% - 125% FPL</td>
<td>126% - 150% FPL</td>
<td>151% - 200% FPL</td>
</tr>
<tr>
<td>1</td>
<td>$0</td>
<td>$12,490</td>
<td>$15,613</td>
<td>$18,735</td>
</tr>
<tr>
<td>2</td>
<td>$0</td>
<td>$16,910</td>
<td>$21,138</td>
<td>$25,365</td>
</tr>
<tr>
<td>3</td>
<td>$0</td>
<td>$21,330</td>
<td>$26,663</td>
<td>$31,995</td>
</tr>
<tr>
<td>4</td>
<td>$0</td>
<td>$25,750</td>
<td>$32,188</td>
<td>$38,625</td>
</tr>
<tr>
<td>5</td>
<td>$0</td>
<td>$30,170</td>
<td>$37,713</td>
<td>$45,255</td>
</tr>
<tr>
<td>6</td>
<td>$0</td>
<td>$34,590</td>
<td>$43,238</td>
<td>$51,885</td>
</tr>
<tr>
<td>7</td>
<td>$0</td>
<td>$39,010</td>
<td>$48,763</td>
<td>$58,515</td>
</tr>
<tr>
<td>8</td>
<td>$0</td>
<td>$43,430</td>
<td>$54,288</td>
<td>$65,145</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $4,420 for each additional person.

Based on 2019 Federal Poverty Guidelines (FPL)
## 1. Applicant Information

**Which office do you go to:**
- [ ] Laurel Fork
- [ ] Ferrum
- [ ] Floyd

**Is this your:**
- [ ] 1st Time Application
- [ ] Renewal Application

<table>
<thead>
<tr>
<th>Name of Responsible Party</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>--------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>SSN</th>
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</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>______________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State</th>
<th>Zip</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
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<td>______________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
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</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>______________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

**Marital Status:**
- [ ] Single
- [ ] Married
- [ ] Separated
- [ ] Divorced
- [ ] Widow/Widower

<table>
<thead>
<tr>
<th>Employer</th>
<th>Employer’s Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

**Do you have health insurance?**
- [ ] yes
- [ ] no

**Do you have pharmacy insurance?**
- [ ] yes
- [ ] no

## 2. Household Members

**Household = Spouse/Significant Other + Tax Dependents**

<table>
<thead>
<tr>
<th>Name (First Last)</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>SSN</th>
<th>Health Insurance</th>
<th>Pharmacy Insurance</th>
<th>Patient at Tri-Area</th>
<th>TAX Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td>☐ or ☐</td>
<td>☐ or ☐</td>
<td>☐ or ☐</td>
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<td>☐ or ☐</td>
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<td>☐ or ☐</td>
<td>☐ or ☐</td>
<td>☐ or ☐</td>
<td>☐ or ☐</td>
</tr>
</tbody>
</table>

## 3. Household Income

**Household = Spouse/Significant Other + Tax Dependents**

<table>
<thead>
<tr>
<th>Monthly/Annual Income</th>
<th>YOU (the Applicant)</th>
<th>Spouse/Significant Other/</th>
<th>Children (over 18)</th>
<th>Others (Must be tax)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF EMPLOYER AND EMPLOYER’S ADDRESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GROSS Wages, Salaries &amp; Tips</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Self Employment or Stmt from Employer</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Social Security &amp; Disability</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Self Declaration of Income</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Workers Comp Benefits</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Child Support &amp; Alimony</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Savings, Interest Income, Pensions</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Rental Property, Stocks, Dividends, Other</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
4. Eligibility Information

- Do you receive food stamps? [ ] yes [ ] no
- Have you applied for Medicaid? [ ] yes [ ] no
- Do you receive any public assistance? [ ] yes [ ] no
- Have you applied for Disability? [ ] yes [ ] no
- Did you file a tax return last year? [ ] yes [ ] no
- Do you consider yourself homeless? [ ] yes [ ] no
- Do you have health insurance? If so, what kind ____________________________
- How much is your Deductible? ________________
- Do you receive child support or alimony? [ ] yes [ ] no

5. Required Proof of Income

- PHOTO ID - a copy of your drivers license or other photo identification.
- PAYSTUBS - last/previous months paystubs of everyone working in the household OR a “Statement of Income from Employer” form from your employer with GROSS earnings for the previous month.
- SELF-EMPLOYED - complete/sign/date a “Self-Employed Statement” form AND make sure to include your Schedule C from your most recent tax return.
- BENEFITS/INVESTMENTS/OTHER INCOME - copies of any benefits checks and/or bank statements for all Investments, Social Security, Disability, Veterans Benefits, Unemployment, Child Support “Paid or Received”, Alimony, TANF/AFDC, Military LES, Pensions, Interest payments, etc.
- TAX RETURN - all pages of your most recent tax return.
- ZERO INCOME - applicants with ZERO income must complete/sign/date a “Zero Income/Statement of Personal Assistance” form. If you are living off of savings, will need a copy of your bank or savings account statement.
- RELEASE OF INFO/INCOME VERIFICATION - if receiving public assistance or you have no/limited income, then complete/sign/date the “Release of Info/Income Verification from the DSS” form.

*If the application is missing any of the above information or is not signed, it will be denied.*

6. Patient Agreement

I certify that all statements contained herein are true and correct and subject to investigation. I authorize the release of employment records and other financial information to an agent of TACH for sliding fee determination purposes. I understand the following:

- I am responsible for payment of all my copays at the time of service.
- I will notify TACH of any changes to my income, household size or insurance status.
- I must renew my application to continue receiving the slide discount (at least annually—more if requested).
- Most routine services are covered under the slide discount. Some procedures, labs, injections and pharmaceuticals are discounted on a separate schedule.
- I understand that if I do not have pharmacy insurance, I may be eligible for pharmacy assistance programs. If eligible, my signature authorizes TACH to share medical, eligibility and financial information with pharmaceutical companies or their designees as required for eligibility or audit purposes.

Applicant’s Signature: ___________________________________________ Date: ___________________
**Sliding Fee Program**

**ZERO Income - Self Declaration of Income**

I, ______________________________, certify that I have NO source of income.

Name of last employer ___________________________ Date of last employment ________________

Household/Family Size: ________

**HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents**

I am currently:

- ☐ Seeking Disability. If so, when did you last apply ________? Have you been denied? ________
- ☐ Other __________________________

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Tri-Area Community Health for sliding fee determination purposes.

Signed: ______________________________ Date: ______________________________

**Instructions:** If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors.

**Statement of Personal Assistance**

I, ______________________________, assist ______________________________ (patient) by providing basic living needs listed below:

- Food: ☐ Yes ☐ No Relationship to Applicant: ______________________________
- Shelter: ☐ Yes ☐ No
- Utilities: ☐ Yes ☐ No
- Money: ☐ Yes ☐ No Amount $________

I can be reached to verify this information at:

My Name (Please print): ______________________________

Address:

Phone:

Signed: ______________________________ Date: ______________________________

*Please list any special circumstances on the back of this form*
Sliding Fee Program

Self Employed Statement of Income

(Complete this form only if you are self-employed)

Business Name: __________________________________________

Business Owner(s): _______________________________________

Business Address: ________________________________________

Business Phone: _________________________________________

Brief Description of Business: __________________________________________

__________________________

GROSS Earnings (FOR THE BUSINESS OWNER = what you paid yourself, NOT the business gross)

Need Past (3) Months. Complete below.

<table>
<thead>
<tr>
<th>Month</th>
<th>20</th>
<th>Month</th>
<th>20</th>
<th>Month</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>$</td>
<td>Week 1</td>
<td>$</td>
<td>Week 1</td>
<td>$</td>
</tr>
<tr>
<td>Week 2</td>
<td>$</td>
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<td>Week 3</td>
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<td>Week 5</td>
<td>$</td>
<td>Week 5</td>
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<td>Week 5</td>
<td>$</td>
</tr>
<tr>
<td>Monthly Total</td>
<td>$</td>
<td>Monthly Total</td>
<td>$</td>
<td>Monthly Total</td>
<td>$</td>
</tr>
</tbody>
</table>

/________________________

Signature of Business Owner Date
Sliding Fee Program

Statement of Income from Employer

(Have your Employer complete this form)

To Whom It May Concern:

Your employee, ___________________________________, is applying for our Sliding Fee Program (to help with medical expenses). In order to process his/her application, we must have proof of their last/previous month’s gross income.

Therefore, please advise us of how much he/she makes per hour, and approximately how many hours he/she works per week.

$____________________ per hour x _____________ hours per week (approximately)

OR, if the above isn’t practical for your type of business, then please complete the following:

GROSS EARNINGS for last/previous month:

Month: __________________________ 20____ $____________________

Name of Employer: __________________________

Direct Supervisor: __________________________

Address: __________________________

Phone: __________________________

____________________ / ______________________

Employer’s signature Date
Applicant’s Name (Last, First, Middle Initial) ________________________________
Date of Birth ________________ SSN# ________________ Home Phone ________________
Address ________________________________ Cell Phone ________________
City, State, Zip ________________________________ Email ____________________
County/City of Residence ________________________________

I hereby authorize __The Department of Social Services__ to release information from my file as indicated below to:

TACH @ Laurel Fork
ATTN: Sliding Fee Program
PO Box 9, Laurel Fork VA 24352
276/398-2292
276/398-3331 FAX

TACH @ Ferrum
ATTN: Sliding Fee Program
PO Box 519, Ferrum VA 24088
540/365-4469
276/398-3331 FAX

TACH @ Floyd
ATTN: Sliding Fee Program
PO Box 835, Floyd VA 24091
540/745-9290
276/398-3331 FAX

INFORMATION TO BE RELEASED:

☑ Notice of Action
☑ Most recent Income Verification
☑ SNAP/TANF/WIC/Energy Assistance/etc
☑ Other ______ Any other public assistance programs ________________________________

AUTHORIZATION:

I am applying for the Sliding Fee Program at Tri-Area Community Health and understand TACH needs my income/public assistance verification from the Department of Social Services. Therefore, I authorize the above organizations to communicate freely between one another for the purpose of income/assistance verification. I understand this authorization will be valid for 12 months from the date signed. I understand that I may cancel this authorization by sending a written request for cancellation to TACH, and the cancellation will take effect when TACH receives my written notice.

______________________________
Signature of Applicant/Patient

______________________________
Date

FOR OFFICE USE ONLY
Faxed __/__/____
Request for Transcript of Tax Return

Do not sign this form unless all applicable lines have been completed.

Request may be rejected if the form is incomplete or illegible.

For more information about Form 4506-T, visit www.irs.gov/form4506T.

Tip: Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-808-9946. If you need a copy of your return, use Form 4506, Request for Copy of Tax Return. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5a If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Tri-Area Community Health Centers, Corporate Office, PO Box 9, Laurel Fork VA 24352 276/398-3331 FAX 276/398-2292 PHONE

5b Customer file number (if applicable) (see instructions)

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 Transcript requested, Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ 1040

   a Return Transcript, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days .

   b Account Transcript, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days .

   c Record of Account, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days .

7 Verification of Nonfiling, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days .

8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days .

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. 12 / 31 / 2018

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. Note: This form must be received by IRS within 120 days of the signature date.

Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Signature (see instructions) Date

Phone number of taxpayer on line 1a or 2a

Sign Here

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2.