

Instructions: If you receive Food Stamps, SSI, or Medicaid, please complete, sign & date this form.



Tri-Area Community Health

SLIDING FEE PROGRAM
Corporate Office, PO Box 9
Laurel Fork VA 24352
276/398-1215
276/398-1273 FAX
www.triareahealth.com

Authorization for Release of Income Verification/DSS Public Assistance Programs for Sliding Fee Application

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:

Tri-Area Community Health
ATTN: Sliding Fee Program Coordinator
PO Box 9, Laurel Fork VA 24352
276/398-1215 • 276/398-1273 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 Sliding Fee Program at Tri-Area Community Health, and understand that 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 for the Sliding Fee Program. I understand that 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 that cancellation will take effect when TACH receives my written notice.

Signature of Applicant

Date

FOR OFFICE USE ONLY
FAXED ___/___/___