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

STATEMENT FROM EMPLOYER

Date: _____

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 two 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: _____ 2011 $_____

Name of Employer: _____

Direct Supervisor: _____

Address: _____

Phone: _____

_____/_____

Employer's signature Date