



# Tri-Area Community Health

Laurel Fork  
276/398-2292

Ferrum  
540/365-4469

Floyd  
540/745-9290

## Sliding Fee Program

Sliding Fee is a special program offered at TACH to assist those who are uninsured or have difficulty paying for medical care. The program offers our patients a broad range of services, including medical, laboratory, x-ray, pharmacy, dental, and behavioral health. Sliding Fee discounts are offered at all of our locations. You may apply regardless of whether you have insurance coverage or not. You must meet income guidelines which are based on family size and family gross income. Proof of income is required and must be current. A list of required sources of income can be found below.

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

### Sliding Fee Income Requirements

*April 5, 2011*

Family Size	Income Level A	Income Level B	Income Level C
	\$30 copay plus \$10 copay for labs and \$15 per x-ray	\$40 copay plus \$10 copay for labs and \$15 per x-ray	\$50 copay plus \$10 copay for labs and \$15 per x-ray
1	\$ 0 – 10,890	\$10,891 – 16,335	\$16,336 – 21,780
2	\$ 0 – 14,710	\$14,711 – 22,065	\$22,066 – 29,420
3	\$ 0 – 18,530	\$18,531 – 27,795	\$27,796 – 37,060
4	\$ 0 – 22,350	\$22,351 – 33,525	\$33,526 – 44,700

*For each additional family member add \$3,820 to the base. Reference: Federal Poverty Level Guidelines, 2011.*

**If your application has not been pre-approved, be prepared to pay the FULL amount at the medical office and/or pharmacy at the time of service.**

#### Required proof of income includes the following:

- Current Slide Application (completed/signed/dated)
- Most recent Income Tax Return form **OR** (if no tax return) a signed/dated 4506T IRS form
- Last/previous month's paystubs **OR** a statement from your employer with GROSS earnings for the previous month
- If self-employed, complete tax return + the Schedule C/CEZ + depreciation schedule
- The previous month's paystubs (of everyone working within the household, see below definition of household) **OR** a statement from your employer stating gross income for last month
- A copy of any benefit checks (Social Security, Pensions, Veteran's benefits, Disability, Unemployment, Alimony, Child Support, TANF/AFDC, Military LES, etc) **OR** a copy of their bank statement (if check is directly deposited into their account)
- Release of Info/Income Verification from the Dept of Social Services (if no/limited income, or if receiving public assistance)
- Self Declaration of Income/Statement of Personal Assistance Letter (if no/limited income)

You may submit the completed application with all required proof of income to any of our medical/pharmacy facilities (or mail them to: TACH SF Coordinator, PO Box 9, Laurel Fork VA 24352). **If the application is missing any of the above income information or is not signed, it will be denied. Incomplete applications will be considered void if all information is not received within 30 days.**

If you have any questions, please call 276/398-1215 or visit our website at [www.triareahealth.org](http://www.triareahealth.org).





# TACH Sliding Fee Application

<input type="checkbox"/> 1 <sup>st</sup> Time Application	Level: _____
<input type="checkbox"/> Renewal	

**MEDICAL OFFICE:**  Laurel Fork  Ferrum  Floyd  
**PHARMACY:**  Laurel Fork  Ferrum

Applicant \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_

**Do you have pharmacy insurance coverage?**  Yourself (Yes/No)  Spouse/Significant Other (Yes/No)  
 Other members of household \_\_\_\_\_ (Yes/No)

IF NO, you may be eligible for pharmacy assistance programs. If eligible, I authorize representatives of Tri-Area Community Health, Inc. to share medical and financial information with RxPartnership and pharmaceutical companies or their designees as required for eligibility verification.

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

\_\_\_\_\_  
*Applicant's Signature* *Date* *Signature of Spouse/Significant Other* *Date*

Did you file a tax return last year?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you receive SSI or Disability income?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are any adults in the household currently working?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have Medicare health insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you receive food stamps?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have Medicare Part B insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you receive any public assistance?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have Medicare Part D insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you receive Child Support or Alimony?	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you or your kids have Famis/Medicaid?	<input type="checkbox"/> yes <input type="checkbox"/> no

**Applicant** \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Employer \_\_\_\_\_ Hourly Wages \$ \_\_\_\_\_ Hours/week \_\_\_\_\_  
 Employer Address \_\_\_\_\_ Annual Salary \$ \_\_\_\_\_ Child Support? \$ \_\_\_\_\_  
 Health Insurance \_\_\_\_\_ Pharmacy Insurance coverage? yes no

**Spouse/Significant Other** \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Employer \_\_\_\_\_ Hourly Wages \$ \_\_\_\_\_ Hours/week \_\_\_\_\_  
 Employer Address \_\_\_\_\_ Annual Salary \$ \_\_\_\_\_ Child Support? \$ \_\_\_\_\_  
 Health Insurance \_\_\_\_\_ Pharmacy Insurance coverage? yes no

**OTHER MEMBERS OF THE HOUSEHOLD:** *List the other family members living in your household that you can legally claim as tax dependents (proof required). List additional family members on the back of this sheet.*

Name \_\_\_\_\_ **\*Is he/she a legal tax dependent?**  yes  no  
 Relationship to Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Health Insurance \_\_\_\_\_ Employer \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Other Income \_\_\_\_\_

Name \_\_\_\_\_ **\*Is he/she a legal tax dependent?**  yes  no  
 Relationship to Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Health Insurance \_\_\_\_\_ Employer \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Annual Income \$ \_\_\_\_\_ Other Income \_\_\_\_\_

## THIS SECTION TO BE COMPLETED BY THE TRI-AREA STAFF

### Front Office Checklist

- Most recent Income Tax Return **OR** a 4506T IRS Form
- If self-employed – the Schedule C or CEZ tax forms
- Last/Previous month's pay stubs
- Benefit Checks (Unemployment/Disability/SSI/Alimony/Child Support)
- Release of Info for DSS **OR** a Notice of Action from DSS
- Income/Food Stamp verification from Soc Services **OR**
- Self Declaration of Income (if no/limited income)
- Statement of Personal Assistance (if no/limited income)

**Application Received By:** \_\_\_\_\_ / \_\_\_\_\_  
 Date Initials

Total Household Gross \$ \_\_\_\_\_  
 Family Size \_\_\_\_\_  
**# of children in household** \_\_\_\_\_  
**Level:**  A  B  C  D

**APPROVED FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

## **Additional Household Members**

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Health Insurance \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**\*Is he/she a legal tax dependent?**  yes  no

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ Other Income \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Health Insurance \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**\*Is he/she a legal tax dependent?**  yes  no

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ Other Income \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Health Insurance \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**\*Is he/she a legal tax dependent?**  yes  no

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ Other Income \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Health Insurance \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**\*Is he/she a legal tax dependent?**  yes  no

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ Other Income \_\_\_\_\_

**PLEASE LIST ANY SPECIALCIRCUMSTANCES WE NEED TO BE AWARE OF:**