Mountain Valleys
HEALTH CENTERS

Sliding Fee Discount Program Information

Please read the following information before completing the Sliding Fee Discount Program Application

Mountain Valleys Health Centers is committed to providing quality, affordable health and dental care to our patients and the communities we serve. As a non-profit, health and dental care provider and recipient of federal funding, MVHC accepts most insurances and welcomes all patients, regardless of their financial standing. The Sliding Fee Discount Program is offered to all patients with or without insurance.

In order to establish your eligibility for this program, MVHC requires proof of your household income, household size, and a commitment from the patient to provide updated information annually to renew eligibility. Examples of documents that prove income may include:

- W-2 Form
- Pay Stubs (2)
- 1099G (Unemployment Benefits)
- Letter from Employer
- Tax Return (required for self-employed earnings)
- Social Security/SSI Benefits Statement Letter
- Bank Statement (showing direct deposit by name)
- Unemployment Stub

Patients whose applications are deemed incomplete may be contacted by an MVHC staff member and additional information or proof of income may be required. An MVHC staff member may also contact patients to assist with determining eligibility for other programs which could reduce out-of-pocket costs for care. MVHC has an enrollment liaison who can answer your questions and help you complete the application. Please call (530) 999-0167.

Patients unable to provide proof of income because no reasonable option for providing it exists, must complete a Self-Declaration of Income Statement to be approved by the Chief Operations Officer or Chief Financial Officer.

Patients that decline or fail to provide the required information will not be eligible for the Sliding Fee Discount Program.

All patients have 15 days from the date of service to submit a completed application with proof of income in order for any resulting Sliding Fee Discount to be applied for that service. Submitting a complete application does not guarantee eligibility for a Sliding Fee Discount, and patients are responsible for all fees incurred until they are determined to be eligible. Applications may be submitted at any time for future service if patients would like to be aware of their Sliding Fee Discount prior to incurring charges, but patients are encouraged to pursue any medical or dental care necessary for their well-being regardless of eligibility.

At minimum, payment of the nominal fee is expected at time of service before eligibility is determined. If eligible for a sliding fee discount, patients may qualify for an additional 10% discount (15% for 65+ for dental service only) by paying sliding fee adjusted fees in full at time of service.

Please acknowledge receipt of the above program information by signing the Sliding Fee Discount Program Application. Please retain this page for your information.

Sliding Fee Application

Applicant Information: *Please provide your information*

Last Name: _____ First Name: _____

Middle Initial: _____ Date of Birth: _____

Phone Number: _____ Cell Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Currently Insured: ☐ Yes ☐ No

Name of Current Insurance _____ Policy Number _____

Other Individuals in my Household for Whom I am Financially Responsible:
This includes all individuals for whom I pay the MVHC bills

Name	Date of Birth	Relationship

Other People in the Household
*Children and all other people **not** listed above who live in your household and who share all money made and bills*

Name	Relationship

**Please provide additional members of the household on the back of this form*

Income Information:

*Please enter all income information for you and all of the people in your household that you included in **either** section on page 1 of this application*

Income for entire household:

- ☐ Monthly $ _____
- ☐ Weekly $ _____
- ☐ Bi-Weekly $ _____
- ☐ Twice a Month $ _____

Is anyone self-employed?

☐ Yes ☐ No

If yes, how much money is brought home every month? $ _____

Other Income Sources	Monthly Total
Alimony/Child Support	$
DisabilityWorkers Comp	$
Education Assistance	$
Interest/Dividends	$
Pensions/Retirement	$
Public Assistance *(not food stamps)*	$
Rental Income	$
Social Security/SSI/Survivor Benefits	$
Unemployment	$
Total	$

Sign Here:

By signing this document, you agree to the statements in the box below

- I acknowledge that I received and understand the MVHC Sliding Fee Discount Program Information.
- I declare the above information is true and correct for all individuals listed on the application.
- I understand that this information will be kept in strict confidence.
- I understand if my income or household size change, I am required to notify MVHC.
- I understand that providing false information will result in the denial of discount benefits and that I will be responsible for the full fee.

Applicant Signature _____ Date: _____

--- For Office Use Only ---

Front Office: Applicant's Patient No. _____ Received Within 15 Days of Service: ☐ Yes ☐ No

Received by: _____ Date Received: _____

Enrollment Liaison: Received Self-Declaration Approval: ☐ Yes ☐ No ☐ N/A

Processed By: _____ Processed Date: _____

Basis of Income Verification: _____

Household Size: _____

Annual Household Income:

_____

Discount Level: _____ Posted Charges: ☐ Yes ☐ No

Patient Notified: ☐ Yes ☐ No Billing Notified: ☐ Yes ☐ No

☐ Application Denied Reason: _____

Effective Date: _____