HHS
Horizon Health Services

# Sliding Fee Discount Program

Thank you for your interest in the Sliding Fee Discount Program offered by Horizon Health Services. We are looking for ways every day to serve those in our area who are uninsured or underinsured. The purpose of this application is to help anyone interested in receiving health care at a reduced rate. Our healthcare services include medical care, dental care, behavioral health, and pharmacy services. All of these services are available to you at a sliding fee discount, if eligible.

Eligibility for the Sliding Fee Discount Program is based solely on the basis of the patient's household size and income and does not discriminate on the basis of age, gender, race, creed, sexual orientation, disability, national origin or legal status.

There are documents that you will need to supply with your application for proof of income. These documents include two current pay stubs, most recent tax return, a notarized letter, or award letters for government benefits. In some cases in which documentation is minimal or non-existent, patient and/or household interviews may be conducted in order to establish the routine living expenses and how these expenses are met. The application must be filled out **completely** before being turned in and it must also have **all** income requested. If the application is not complete it will not be processed. If you have any questions about how to complete a section of the application then please ask the front desk staff or call any of our offices.

| **Ivor Medical Center** | **Ivor Dental Center** | **Surry Medical Center** | **Waverly Medical Center** | **Horizon Pharmacy** |
|---|---|---|---|---|
| 8575 Ivor Road | 8579 Ivor Road | 440 Colonial Trail W | 344 W. Main Street | 328 W. Main Street |
| Ivor, VA 23866 | Ivor, VA 23866 | Dendron, VA 23839 | Waverly, VA 23890 | Waverly, VA 23890 |
| 757-859-6161 | 757-859-9070 | 757-294-3981 | 804-834-8871 | 804-429-8602 |

# Frequently Asked Questions

**How long does it take to process the application?**

Once our office has received the Sliding Fee Discount Program application, please allow seven (7) business days for our staff to review and process the application.

**What if I have no source of income?**

If you have no source of income, you will need to complete ***Form A*** and a notarized ***Form B*** completed by whomever is financially assisting you (HHS can assist with the notary service).

**What if I am self-employed, can I still qualify?**

Yes, if you are self employed, all you need to have is the most recent income tax return.

**What is the definition of household?**

A "household" is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. If a family has an individual residing in the household, but the family does not consider that person be a part of the family, the family must demonstrate that the finances of the individual are separate and of no consequence to the family or else the income of the individual is considered as part of the household.

**What is the definition of income?**

Income includes: earnings, unemployment compensation, worker' compensation, Social Security, Supplemental Security Income (SSI), public assistance, Temporary Assistance for Needy Families (TANF), veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

**What if my household income changes in the year?**

If there is a change in household income, it is your responsibility to report to HHS those changes before or at the time of your next visit or visit by a member of your family.

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# APPLICATION FOR FINANCIAL ASSISTANCE
# SLIDING FEE DISCOUNT PROGRAM

## *Patient Information*

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____

**STREET ADDRESS:** _____

**MAILING ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**PRIMARY PHONE:** _____ **SECONDARY PHONE:** _____

**SOCIAL SECURITY #:** _____ **MARITAL STATUS:** _____

## *Household Members*

| Name | DOB | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PLEASE COMPLETE NEXT PAGE WITH HOUSEHOLD INCOME.**

***Please read and initial the following:***

_____ **I AGREE THAT ALL INFORMATION I HAVE GIVEN CONCERNING THE SIZE OF MY HOUSEHOLD AND MY HOUSEHOLD INCOME FROM ALL SOURCES IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

_____ **I REALIZE THAT KNOWINGLY GIVING FALSE INFORMATION IN THIS CASE MAY RESULT IN CRIMINAL PROSECUTION UNDER VIRGINIA LAW.**

_____ **I UNDERSTAND I AM REQUIRED TO REAPPLY ANNUALLY WITH NEW PROOF OF INCOME.**

_____ **I UNDERSTAND IF I FAIL TO RETURN APPLICATIONS AND/OR INCOME PROOF I WILL BE RESPONSIBLE FOR ALL CHARGES.**

_____ **I UNDERSTAND IF I DO NOT COMPLY WITH THE ABOVE LISTED GUIDELINES I WILL NEED TO SIGN A PAYMENT AGREEMENT IF I CANNOT PAY THE BALANCE IN FULL.**

_____ **I UNDERSTAND THAT HORIZON HEALTH SERVICES, INC. IS NOT A FREE CLINIC. I MUST PAY THE NOMINAL FEE/COPAY AT THE TIME OF MY VISIT.**

_____ _____

***Patient/Responsible Party Signature*** ***Date***

## FOR OFFICE USE ONLY

Date Received: _____ Application Processed By: _____

Date Reviewed: _____

Action Taken: A B C D E DNQ

Expiration Date: _____ Retroactive Date: _____

**APPLICATION FOR FINANCIAL ASSISTANCE**
**SLIDING FEE DISCOUNT PROGRAM**

## *Household Income*

*Totals must be completed for each household member, if member has zero income, please indicate.*
***Be sure to clarify how often payments are received from each resource. (weekly, every 2 weeks, twice a month, or monthly)*

| Income Type/Resource | Applicant | | Spouse | | Child | | Other | | Subtotal |
|---|---|---|---|---|---|---|---|---|---|
| | Frequency | Amount | Frequency | Amount | Frequency | Amount | Frequency | Amount | |
| Wages, salaries, & tips (two current pay stubs or most recent tax return or Form C) | | | | | | | | | |
| Self employment income (most recent tax return) | | | | | | | | | |
| Unemployment compensation/ Worker's compensation benefits | | | | | | | | | |
| Social Security Benefits SSA (award letter) | | | | | | | | | |
| Disability SSI (award letter) | | | | | | | | | |
| Alimony (award letter or bank statement) | | | | | | | | | |
| Child Support (award letter or bank statement) | | | | | | | | | |
| Pensions/Annuities | | | | | | | | | |
| Other: | | | | | | | | | |
| Other: | | | | | | | | | |
| **Totals:** | | | | | | | | | |

**Please attach all proof of income to this application for review**

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FORM A

# Self-Declaration of Income

Anyone applying for financial assistance with no source of income must complete this form.

Also, **FORM B** must be completed/signed by the person providing financial support and returned along with the completed application for financial assistance.

## *Patient Information*

**PATIENT NAME:** _____ **BIRTH DATE:** _____

**SOCIAL SECURITY #:** _____

## Self Declaration of Income - ZERO Income *(to be completed by patient)*

I, _____, am currently unemployed. I do not have any income, from any source, including Social Security, welfare, pension/retirement, child support/alimony, or checks from the Department of Human Services for myself or dependent household members. I have NO income at this time.

I will inform Horizon Health Services, Inc. of changes in my employment status and provide proof of income to support my application for assistance through the Sliding Fee Discount Program. I understand that misleading or false statements will prevent me from participating in this program.

_____ _____

***Patient/Responsible Party Signature*** ***Date***

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# Verification of Support

FORM B

**THIS FORM MUST BE NOTARIZED.**

## Verification of Support *(to be completed by the person(s) providing financial support)*

I, _____, verify I provide in-kind assistance to _____. To my knowledge he/she has no income from any source or limited income from _____.

I am currently providing the following basic living needs for the person listed above:

| | | | |
|---|---|---|---|
| Food: | □ Yes | □ No | |
| Shelter: | □ Yes | □ No | |
| Utilities: | □ Yes | □ No | |
| Money: | □ Yes | □ No | Amount $ _____ |
| | | | How Often? _____ |

By signing this, I verify that, to the best of my knowledge, the above named person has no income from any source or limited income. I understand that if I give false information that I can be prosecuted for perjury, larceny, and/or fraud.

**Signature of person providing financial support:** _____

**Date signed:** _____

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Form C

# Income Statement from Employer

If an applicant is unable to provide required **pay stubs** (i.e., pay stubs are not available and/or applicant has started employment and pay stubs have not yet been received) the applicant must provide a completed and signed *Income Statement from Employer* form from **each** employer. Once verified, the applicant will be considered for eligibility determination for Sliding Fee Discount Program.

If an applicant is **paid cash** from one or more employer's (individuals, businesses, and/or organizations), or is **paid cash** from individuals, businesses and/or organizations for casual labor, day labor and/or domestic service (e.g., gardening, landscaping, housekeeping, daycare, babysitting, etc.) and the cash paid is **not** included on the applicant's tax return, the applicant must provide a completed and signed *Income Statement from Employer* form from **each** employer and **each** non-employer (i.e., individuals, businesses, and/or organizations) for services. Once verified, the applicant will be considered for eligibility determination for the *Sliding Fee Discount Program* .

**THIS FORM MUST BE NOTARIZED.**

## *Patient Information*

**PATIENT NAME:** _____ **BIRTH DATE:** _____

**SOCIAL SECURITY #:** _____

## Employer/Non-Employer *(to be completed by employer/non-employer)*

Name (individual/business/organization): _____

Address: _____

City, State Zip Code: _____

Contact Phone: _____

Contact Name: _____

Date of Hire: _____

Hourly Wage $: _____

# of Hours/Week: _____

How often does applicant get paid? Weekly _____ Bi-Weekly _____ Monthly _____

I understand Horizon Health Services, Inc. may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the applicant's eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately.

**Completed by (printed name):** _____ **Title:** _____

**Signature:** _____ **Date signed:** _____