Southern Dominion Health System, Inc.

SLIDING FEE APPLICATION

Employed Patients - Must provide at least one of the following:
- ___ Last 3 consecutive pay stubs
- ___ Current W2
- ___ Current Tax Return (If self-employed please provide Profit & Loss Statement)
- ___ Statement from Employer (Must have company name, contact phone number, and signature)

Child Support - Must provide at least one of the following:
- ___ Court Order
- ___ Division of Child Support Awards Letter

Social Security - Must provide at least one of the following:
- ___ Awards Letter from Social Security Administration
- ___ Copy of benefits check

Unemployment - Must provide at least one of the following:
- ___ Unemployment Awards Letter
- ___ Denial Letter
- ___ Letter stating all benefits have been depleted

Food Stamps - Must provide at least one of the following:
- ___ Awards Letter from Department of Social Services
- ___ Denial Letter from Department of Social Services

Inheritance/ Court Ordered Payments/ Spousal Support - Must provide at least one of the following:
- ___ Court order

No verifiable Income - Must provide at least one of the following:
- ___ SDHS Unemployment Statement
- ___ Letter of Support from whomever is supporting applicant and dependents financially
  - Letter must have the person's name and contact information

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- The Sliding fee discount is based on: Household income and Number of dependents in the household
- There are 3 different levels of Sliding fee discounts (lab/ x-ray discounts **DO NOT** apply to patient with insurance):
  - Slide A – A patient is required to pay $15.00 per office visit. All x-rays and labs included
  - Slide B - A patient is required to pay $30.00 per office visit, $7.00 per x-ray and $3.00 per lab
  - Slide C - A patient is required to pay $35.00 per office visit, $10.00 per x-ray and $5.00 per lab
  - Slide D- A patient is required to pay $40.00 per office visit, $13.00 per x-ray and $7.00 per lab
- All charges may not be covered by the Sliding Fee such as but not limited to Depo-Provera and Pregnancy test.
- All applicants will be notified of their Slide application effective and expiration dates thru a SDHS Awards letter. It is your responsibility to provide all required information when returning your application. An incomplete application will **NOT** be accepted nor processed.
- Nonpayment of Sliding Fee Co-pay/ Lab Charges after **three** visits will cause the patient to be removed from the slide until the account balance is paid in full. Once your account balance is brought current, you will be eligible to reapply for the slide.
- Any change of financial status must be reported as soon as possible, and a new application must be completed.

By signing below, I acknowledge that I have read and understood the above guidelines and intend on following them to the best of my ability.

_____ _____

Signature of Applicant **Date**

Southern Dominion Health System, Inc.

SLIDING FEE APPLICATION

Name: _____ **Social Security #:** _____

Address: _____
(Mailing address) CITY STATE ZIP

Home Phone #: _____ **Work Phone #:** _____

Are You Married? _____**Yes** _____**No** **Date of birth:** _____

Please list spouse and dependents in the household and their date of birth and social security #:

Name:	Birth Date:	Relationship:	Social Security #:

Employer Name: _____
Address: _____
Length of Employment: _____ **Gross Annual Salary:** _____
Spouse's Employer: _____
Address: _____
Length of Employment: _____ **Gross Annual Salary:** _____

Financial Information (We must have proof of income for all household members!)

Sources of Income:
Wages/Salary: _____ **per week, bi-weekly or monthly (please circle one)**
Welfare/ Food Stamps: _____
SSA Payment/Type: _____
Spouses SSA Payment/Type: _____
Unemployment Benefits: _____ **Date of Layoff** ____/____/____
Child Support: _____
Workers' Compensation: _____
Other: _____

***If application is not completed in its entirety, it will not be processed, and it will be returned for completion.**

I understand that I must report any and all income changes as they occur and if I do not, then I forfeit my rights to be on the Sliding Fee Discount. I certify that the above information is true and correct to the best of my knowledge.

This application must be returned in 10 days from date listed below.

_____ _____
(Signature) **(Date)**

FOR OFFICE USE ONLY:
Approval Signature: _____ **Date:** _____

Sliding Fee Rate: _____ **Account #:** _____ **Renewal Date:** _____

Mailing Address: PO Box 70 Victoria, VA 23974

Revised 07.05.22