For office use only
Date Received: _________
Returned by: __________
BRMC Staff: __________

BLUE RIDGE MEDICAL CENTER

4038 Thomas Nelson Highway, Arrington, VA 22922
Phone: 434-263-4000 Fax: 434-263-4160 Email: slide@brmedical.com

APPLICATION FOR FINANCIAL ASSISTANCE - SLIDING SCALE PROGRAM

APPLICATIONS WILL NOT BE PROCESSED ON THE DAY OF SERVICE!
Applications without proof of all Income or Support will NOT BE PROCESSED!
(See back for instructions.)

Name: ______________________ SSN: ______________ Birth Date: ____________

Mailing Address: ______________________ City: __________ State: _______ Zip: ________

Physical Address: ______________________ City: __________ State: _______ Zip: ________

Email Address: ______________________

Telephone #: Home: ______________ Cell: ______________ Work: ______________

"*Family/Household*" includes the Applicant and dependents** (as defined by IRS), *AND* any SPOUSE / PARTNER / FIANCE in the home.
** If someone claims you as a dependent, then list all other family members.

Family/Household members: *If more space is needed, attach a separate sheet.*	Date Of Birth	Relationship To Applicant	Monthly Gross Income: *PROOF is required (See Back)*	Employer Name (if employed) or Source of Income	Full Time Student? Yes/No	Race (ie: White, Asian, African American, Native American, etc.)
		Self				

How many are in your family/household? ________ If Unemployed, date employment ended: ______________

Applicant: How often are you paid? __________ Date Employment Began: __________ Employer Phone No.: ____________

Other: How often are you paid? __________ Date Employment Began: __________ Employer Phone No.: ____________

If you have NO, or VERY LOW, income *PROVIDE PROOF* of how you are supported? ______________________________

PROVIDE *PROOF* / DOCUMENTATION of any of the following as well:

Food Stamps: Yes / No Amount: $	Unemployment wages: Yes / No Amount: $
Child Support: Yes / No Amount: $	Disability: Approved or pending Yes / No Amount: $
Spousal Support: Yes / No Amount: $	Do you *Receive* rental income? Yes / No Amount: $

Do you or others in the household have health insurance? Yes / No Name(s): ______________ Insurance? ______________
(including Medicare or Medicaid) Name(s): ______________ Insurance? ______________

DECLARATION: The information provided above is, to the best of my knowledge and belief, complete, accurate and true. I understand that if I give false information, withhold information, or fail to report changes in my income, I will be disqualified from this program; and could be prosecuted for perjury, larceny, and/or fraud. I authorize the release of all information which Blue Ridge Medical Center may need to determine whether I qualify for financial assistance through the Sliding Scale Program.

Applicant **Signature**:	Date:
Other adult and/or Partner Signature: (see # 3 on Reverse)	Date:

Office Use Only (below this line)

BRMC: Income: ____________ S.S. Status: _____ Eff. Dates: ________________ Migrant? _______ Date/Init.: ________

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Blue Ridge Medical Center Pharmacy charges and charges for some Dental procedures and services are exempt from the Sliding Scale. However, some discounts may apply for eligible patients. Eligibility will be based on information supplied in this application.

1. **Fill in every blank field and *ATTACH PROOF OF ALL INCOMES*.** If no income, see "UNEMPLOYED - NO INCOME", below. Incomplete applications & applications missing income documentation/support ***will*** be returned and significantly delay processing. **You will be expected to pay full fee for charges until your application is complete.**

2. **Other Adults in home**: If you are a spouse/partner/boyfriend/girlfriend/partner/fiancé, or otherwise "significant other", in the home, ***proof*** of your income is REQUIRED. If you are an adult "**dependent**" – see #3.

3. **"Other Adult and/or Partner" -** Please sign this application if you live in the home and wish to be considered for this program **AND** you are either:
   - An adult child of the applicant. (**Dependent adult children must provide PROOF of dependence – IRS 1040**); OR
   - An unmarried partner (fiancé, girlfriend, boyfriend) of the applicant.

The following types of documentation are required, as applicable, to document your income:

- **EMPLOYED**:
  - If employed during total of previous tax year, then the prior year's IRS 1040 Income Tax Return, or
  - 1 month's worth of **CURRENT** pay stubs showing gross income, or
  - A letter from your employer stating 1 current month's gross salary
- **SELF EMPLOYED**: Prior year's Federal Income Tax return (IRS 1040), along with Schedule C
- **UNEMPLOYED – LOW/NO INCOME:** Written statement from family or friend verifying financial support and lack of income &/or employment.
- **UNEMPLOYMENT/WORKER'S COMPENSATION:** Documentation verifying weekly benefit amount, or Denial
- **GOVERNMENT BENEFITS**: Social Security, SSI, VA, Disability, or other government benefits
  - Social Security Letter confirming or denying, and listing monthly gross amount (Bank statement can **NOT** be used)
  - IRS 1099 showing yearly amount (if received for total year)
- **SOCIAL SERVICES:**
  - SNAP "Notice of Action" for Food Stamps, Aid to Dependent Children, TANF, Housing, etc.
- **OTHER RESOURCES**: Provide legal proof, or official award letter
  - Retirement benefits
  - Trust fund allotments
  - Child Support and/or Alimony – received only
- **HOMELESS:** Letter from shelter, if client is homeless
- **LIQUID ASSETS**: Provide statement(s) from Bank or Credit Union
  - Investments, CD'S, Interest, Dividends
- **OTHER:** As appropriate **-** Copy of custody papers for dependents listed, if income is too low to file taxes.

Comments: ***You may use this area to explain any unusual circumstances which you feel may be helpful.***