

### **Blackstone Valley Community Health Care, Inc. Reduced Fee Application**

Blackstone Valley Community Health Care, Inc. (BVCHC) is a non-profit community health center. We receive limited funding from many different sources so that we can provide medical and dental care based on a reduced fee schedule for our self-pay and under-insured patients. Reductions in charges are determined Family Size and Household Income. The income guidelines used are a percentage of the current year's Federal Poverty Guidelines.

In order to qualify for a reduction in charges we must receive a completed application with proper documentation and proof of income. The income documents will remain on file and all information gathered in this application process will be highly confidential.

If approved, the application is valid for a period of one year\*, after which you will be required to submit a new application and new income documents. **You may request an appointment with an Outreach and Enrollment Coordinator to assist you with the application process.**

The following checklist will assist you in providing a completed application. You will need:

☐ **Completed Application Form**

- List ALL members of your household on the application
- Supply income documents for qualified household members
  - Age 18 and older if employed
  - If 18+, no income and Full time Student, please indicate FTS
  - If 18+, no income, not a student – Support Letter will be needed.

☐ **Acceptable Forms of Income Documentation Include:**

- Prior Year W2 Form from Employer – can only be used from Jan 1 through April 30 each year. After April 30, must use 1040 Tax Return.
- If paid Weekly – Requires 4 current and consecutive pay stubs, must show gross income
- If paid Bi-Weekly – Requires 2 current and consecutive pay stubs, must show gross income
- Letter from your Employer
  - Company letterhead is preferred, but not required
  - Letter must have Name of Company, Name and Title of person signing and a contact telephone number.
  - Must include Hourly Wage Amount and total number of hours worked per week.
- Federal Form 1040 Tax Return for the most current Tax Filing Year.
- Federal Form 4506-T – Transcript of Tax Return for most current tax filing year
- If Self-Employed – details of the most recent 3 months of income and expenses for the business
  - If no documents available, complete the Self Declaration of Income Form
  - \* If the Self Declaration of Income Form is approved, it will only be valid for 6 months. A new application and income verification will be required no later than every 6 months.

Initial Received By: \_\_\_\_\_

Date Received at BVCHC: \_\_\_\_\_

**SLIDING FEE DISCOUNT PROGRAM APPLICATION**

Today's Date: \_\_\_\_\_

Last Name, First Name	Relationship (Self, spouse, partner, child, friend, etc.)	Date of Birth	If applicable, Medical Insurance Carrier and ID number (Optional)	Monthly Gross Income	Annual Gross Income	Acct # BVCHC Staff use only

If Additional Household Members add on a Separate Sheet if needed and check this box ☐

Guarantor/Head of Household Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# (Optional): \_\_\_\_\_

Mailing Address:

Street: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email: \_\_\_\_\_

- Once it is determined that you are eligible for reduced rates, we can apply that reduced rate to qualifying visits.
- There is a \$20.00 nominal fee due at time of visit for all patients who apply for a reduced fee for medical services. There is a \$40.00 nominal fee due at time of visit for all patients who apply for a reduced fee for dental services. The nominal fee is not a threshold for receiving care. Also, please note the amount due may change and you may be balanced billed if:
  - The services provided to you during your visit did not qualify for reduced fees.
  - If you are determined to be partially eligible at a higher nominal fee amount.
  - If you do not qualify for the fee reduction at all based on all documentation.

**You are not guaranteed reduced rates unless the documentation of income is within the reduced Fee Income Guidelines.**

If you have any questions regarding the documentation of income or reduced fee program, please call (401) 729-0081 and ask for an Outreach and Enrollment Coordinator.

*"By signing below, I certify all the information given on this application is correct and completed to the best of my knowledge. I give permission for BVCHC to verify any information needed to determine my eligibility. I understand that all information is confidential and will only be used in connection with enrollment in the reduced fee program."*

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**TO BE COMPLETED BY BVCHC STAFF ONLY**

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Proof of income was received and verified: Yes \_\_\_\_\_ No \_\_\_\_\_

Initials of employee: \_\_\_\_\_ Date: \_\_\_\_\_

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