APPLICATION FOR REDUCED FEE STATUS

2019 FEDERAL POVERTY GUIDELINES

MEDICAL:	SLIDE A NOMINAL FEE $15.00	SLIDE B NOMINAL FEE $20.00	SLIDE C NOMINAL FEE $30.00	SLIDE D NOMINAL FEE $40.00
BEHAVIORAL HEALTH	NOMINAL FEE $ 5.00	NOMINAL FEE $ 7.50	NOMINAL FEE $10.00	NOMINAL FEE $15.00

Household Size	Monthly Income	Annual Income	Monthly Income	Annual Income	Monthly Income	Annual Income	Monthly Income	Annual Income
1	$1,040.83	$12,490	$1,040.84- $ 1,561	$18,735	$1,561.01- $1,821	$21,858	$1,821,01- $2,081.67	$24,980
2	$1,409.17	$16,910	$1,409.18- $2,114	$25,365	$2,114.01- $2,466	$29,593	$2,466.01- $2,818.33	$33,820
3	$1,777.50	$21,330	1,777.51- $2,666	$31,995	$2,666.01- $3,111	$37,328	$3,111.01- $3,555.00	$42,660
4	$2,145.83	$25,750	$2,145.84- $3,219	$38,625	$3,219.01- $3,755	$45,063	$3,755.01- $4,291.67	$ 51,500
5	$2,514.17	$30,170	$2,514.18- $3,771	$45,255	$3,771.01- $4,400	$52,798	$4,400.01- $5,028.33	$ 60,340

For each additional person, add $368.00 to monthly income or $4,420.00 to annual income

If your household income meets the guidelines listed above, you may qualify for reduced fees. If you wish to apply for reduced fees, please complete this application. Documentation of your household income must be provided to verify your status.

PATIENT NAME: _____ **# Dependents in Household:** _____

If you are over 18, do you live in someone else's home other than your family? ☐ **Yes** ☐ **No**

IF YOU DO NOT WISH TO APPLY AT THIS TIME, PLEASE CHECK THE BOX BELOW:

☐ **I UNDERSTAND THAT I HAVE THE RIGHT TO DECLINE REDUCED FEE STATUS; HOWEVER, IF AT ANY TIME MY FINANCIAL STATUS CHANGES, I CAN APPLY FOR REDUCED FEE STATUS AT THIS FACILITY.**

PLEASE LIST ALL HOUSEHOLD MEMBERS MUST INCLUDE PATIENT	CLAIMED AS DEPENDANT FOR TAXES? PLEASE PRINT YES/NO	RELATIONSHIP /AGE	DO THEY RECEIVE INCOME?		IF YES, LIST SOURCE OF INCOME: *(WHERE YOU WORK OR TYPE OF INCOME RECEIVED: SS, TANF, UNEMPLOYMENT, CHILD SUPPORT, ETC.)*	INCOME AMOUNT *(MONTHLY OR ANNUAL ACCEPTED)*	
			YES	NO		MONTHLY AMOUNT	ANNUAL AMOUNT
		/				$	$
		/				$	$
		/				$	$
		/				$	$
		/				$	$

Statement of Understanding:

The information provided about family size and gross annual income from all sources is true, accurate and complete to the best of my knowledge. Information concerning my financial situation, means and ability to pay is given for the purpose of obtaining a discount on my accounts with Bassett Family Practice (BFP or RFH) or Ridgeway Family Health (RFH) for my own and my family's benefit. I understand BFP or RFH will rely on such information to determine applicable discount rates for my account. I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the Commonwealth of Virginia.

I agree to report any change(s) in either my income or family size to BFP or RFH before or at my next contact or any contact by any family member with BFP or RFH. I know that the information I have given will continue to be relied upon until it is changed. I understand that my discount status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If BFP or RFH has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, BFP or RFH may initiate a review of my status. I hereby authorize the investigation of all statements contained herein and authorize the release of all employment records, bank record, and other financial information to an agent of BFP or RFH.

APPLICATION MUST BE ACCOMPANIED BY PROOF OF FINANCIAL SITUATION BEFORE DISCOUNT WILL BE APPLIED. PROOF OF INCOME MUST BE PROVIDED WITHIN THIRTY (30) DAYS OF THIS VISIT IN ORDER TO CONTINUE REDUCED FEES FOR OTHER VISITS. FAILURE TO PROVIDE VERIFICATION WILL RESULT IN LOSS OF REDUCED FEES AND YOU WILL BE CHARGED FULL PRICE FOR YOUR VISIT. ***My signature below indicates that all information I have provided is true to the best of my knowledge***.

_____

Signature /Date

APPLICATION MUST BE RENEWED ANNUALLY WITH UPDATED PROOF OF INCOME

Brakes/Documents/BassettFamilyPractice/Forms/FrontOffice/ReducedFeeApplication.2019

Written: January, 2008 Revised: 09/2008; 02/2009/01/2011; 04/2011; 01/2012; 01/2013; 02/2014; 02/06/2015; 03/2015; 03/2016; 02/2017; 01/25/2018; 01/22/2019