

Return Application by: \_\_\_\_\_

## DISCOUNT PROGRAM APPLICATION

APPLICANT INFORMATION					
Last Name:	First Name:			Middle Initial:	
Mailing/Street Address:	City:	State:	Zip Code:		
Phone #:	Social Security:			Date of Birth:	
County you live in:				# in Household:	
Insurance (if any):	Medicaid	None			
	Medicare	Other (specify)			

HOUSEHOLD INFORMATION <small>(List all in household, related by blood/marriage/adoption &amp; financially responsible for each other.)</small>					
Last Name	First Name	Social Security #	Date of Birth	Relationship to Applicant	Also Applying Yes
				Self	

\*Please checkmark here if additional individuals are listed on back .

TYPE OF INCOME RECEIVED BY HOUSEHOLD						
Source	You	Spouse/	Other	Total	How many ti	
	Yes	Partner			Monthl	Per
Salary/Self Employment						
Unemployment						
Social Security/Disability						
Pensions/Annuities/Other						

## DISCOUNT PROGRAM APPLICANT AGREEMENT

- I understand my discount percentage may change upon final review of my application.
- I understand I must provide acceptable proof of income for each person listed on this application.
- I understand it is my responsibility to notify Valley Health of any changes in above information provided.
- I understand I must renew my application each year- with proof of income to remain an active participant.
- I have read additional terms of the Sliding Fee Discount Program Policy, and agree to each.

I hereby certify that the information provided on this application is accurate and I authorize Valley Health

Systems to verify any of the information provided above.

REQUIRED: Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN COMPLETED APPLICATION WITH DOCUMENTATION TO YOUR VALLEY HEALTH CENTER OR TO THIS ADDRESS:**

Valley Health-Business Office; Attn: Sliding Fee Coordinator \* 5636 Route 60, Suite 1B\* Huntington, WV 25705

