SLIDING FEE DISCOUNT PROGRAM APPLICATION

LAST NAME:	**Please check one:**
FIRST NAME:	Initial Application
MIDDLE INITIAL:	Recertification
STREET ADDRESS:	
CITY:	
STATE/ZIP:	
TELEPHONE:	
DOB Social Sec #	
Today's Date:	

MONONGAHELA VALLEY ASSOCIATION OF HEALTH CENTERS

It is necessary for MVA to ask personal questions in order to give you a discount on your medical expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least annually. Your yearly income tax return, W2 form, or recent payroll checks covering is needed. Your income and household size is used to determine your discount.

Do you receive income from the following sources? If so, how much and how often (ie. Weekly, monthly, yearly)

Sources	*Yourself (amount)*	*How Often?*	*Spouse (amount)*	*How Often?*	*Others (amount)*	*How Often?*	*Total Income*
Employment							$ -
Social Security							$ -
Retirement/Pension							$ -
Rental Income							$ -
Interest Income							$ -
Child Support/Alimony							$ -
Other (Specify)							$ -
Other (Specify)							$ -
Other (Specify)							$ -
TOTAL	$ -		$ -		$ -		$ -

How Many People are in your Household?

So that we can apply the discount to all members of your household please list:

Name	Date of Birth	Relationship

I certify that the above information is true and have given MVA permission to verify any information in this application. Willfully submitting false information may result in cancelation of my participation in the Sliding Fee Discount Program. If complete information is not submitted to MVA **within 14 days, then I understand that I will be billed full cost for all services provided**. I also understand that this is a discount program only for MVA's services and does not constitute insurance coverage .

Applicant Signature:	***Date:***

CLINIC USE ONLY:

Approved by: _____	***Slide Percentage:*** _____
Date of Approval: _____	***Notes:***
Date of Expiration:	