Medical/Behavioral Health/Audiology Slide

Slide Name	% Of Federal Poverty Level	Nominal Payment
A	0-100%	$20
B	101-133%	$40
C	134-166%	$60
D	167-200%	$75

Dental Slide

Slide Name	% Of Federal Poverty Level	Nominal Payment
A	0-100%	$85
B	101-133%	$90
C	134-166%	$100
D	167-200%	$115

Vision Slide

Slide Name	% Of Federal Poverty Level	Professional Services & Diagnostic	Select Frames & Lenses
A	0-100%	$65	50% OFF
B	101-133%	60% OFF	40% OFF
C	134-166%	50% OFF	30% OFF
D	167-200%	40% OFF	20% OFF

Surgical Slide

Slide Name	% Of Federal Poverty Level	Nominal Payment
A	0-100%	$100
B	101-133%	$200
C	134-166%	$300
D	167-200%	$400

Select Hearing Aids Slide

Slide Name	% Of Federal Poverty Level	Discount Amount
A	0-100%	**40%**
B	101-133%	**35%**
C	134-166%	**30%**
D	167-200%	**25%**

What is a Nominal Payment?

A payment made for all services provided on a calendar date. Payment includes laboratory and radiology services provided and must be made at time of service. Valley Health, however, serves all patients regardless of ability to pay.

VALLEY HEALTH
2585 3rd Ave • Huntington, WV 25703

VALLEY HEALTH
Quality healthcare in your neighborhood.

Discounted Health Services

Our Sliding Fee Program Can Help

Valley Health's Sliding Fee Program is designed to help qualified patients reduce their bills for routine health services at our facilities. Eligibility is based on family size and income.

How Do I Apply?

To receive Sliding Fee discounts, every adult member of the household must apply for coverage separately with a signed application and proof of household income. All other methods of coverage must be exhausted (CHIPS, Cancer Control, Family Planning, State Assistance) prior to initiating the application process.

Sliding Fee applications will only be printed when a patient brings proof of income or a medical denial from DHHR. Applications should not leave the Valley Health office.

1. Bring proof of income as defined by our application to your local health center.
2. Complete Sliding Fee application on-site.
3. Sign the application.
4. Attach documents verifying household income

* Please avoid turning in the application during urgent care hours.

What Happens Next?

IF ELIGIBLE, you will receive a Sliding Fee Program card in the mail and may begin using it to receive discounted services at any Valley Health facility.

IF INELIGIBLE, you will receive a letter stating why participation is being denied.

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While the health center may provide preliminary approval and an **ESTIMATE** of your level of discount upon receipt of the application, no application or discount level is final until our central office reviews it.

Questions? Call 304.697.1396.

This is the first page of the Sliding Fee Application. The second page of the application must be obtained from a health center. Proof of income must be attached before an application may be processed.

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Quality healthcare in your neighborhood.

Date of Application:

Sliding Fee Application

Valley Site:_____

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and your family, you will need to complete the Sliding Fee Scale program application and provide verification of income.

Head of Household Information:

Name: (First, middle initial, last)	Account number:	Date of Birth:	County:
Address	City/State/Zip	Home Phone:	Work phone:

Income Information: Please complete this section for all adult household members who are employed, plus **SUBMIT PROOF OF INCOME, consisting of your two most recent check stubs (if you are paid bi-weekly), or your four most recent check stubs (if you are paid weekly). Paystubs must show current and year-to-date earnings and must be consecutive pay periods. IF THERE IS NO INCOME TO REPORT, THE APPLICANT MUST PROVIDE A COPY OF A DENIAL FOR MEDICAL ASSISTANCE FROM MEDICAID.** Otherwise, services will be rendered at customary price. **If your income is $0, how are you meeting your food, clothing, shelter and transportation needs?**

Employed Person	Company Name	Income (Before Taxes)	Paid how often? (Check One)
			☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
			☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
			☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I. $	Social Security $
Unemployment $	Worker's Comp $	Dividends $	Other $

Household Information: List ALL individuals in household, including the head of household:

Name	Date of Birth	Relationship	SSN	Employed
1.				**Yes/No**
2.				**Yes/No**
3.				**Yes/No**
4.				**Yes/No**
5.				**Yes/No**
6.				**Yes/No**
7.				**Yes/No**
8.				**Yes/No**
9.				**Yes/No**

www.valleyhealth.org

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