Today's Date:_____

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

Blackstone Valley Community Health Care, Inc. (BVCHC) is a nonprofit community health center. We receive limited funding from many different sources so that we can provide medical and dental care based on a reduce fee schedule for our self-pay and under insured patients. In order to be considered for a reduction in charges we need to document your income level and keep this confidential information on file. Please list everyone living in the household and their income.

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

Guarantors Name: _____ SS#: _____

Address: _____ Apt # /Floor: _____

City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

**Important Notes:**
Documentation of income that can be used to evaluate eligibility for reduced fees might include: (1) most recent copy of Federal Income Tax Filings for anyone living in the household. (2) last 2 paystubs for anyone living in the household over the age of 18 (3) as a last resort we can consider the last few Bank Statements provided all the deposits are supported with appropriate supporting documentation.

* New documentation of income must be resubmitted **annually** for re-evaluation of eligibility. The eligibility period runs from 5/1 through 4/30 of each year. Therefore a new application must be submitted for appointments beginning 5/1 of each year.

* New documentation of income must also be re-submitted and re-verified if there is any change in the number of people in the household and/or a material change in the gross household income.

*Once it is determined that you are eligible for reduced rates we can apply that reduced rate to qualifying visits.

*Payment for any applicable reduced fees is expected at the time of each visit. If you are determined to be ineligible for reduced fees, then the full charge(s) for each visit is expected at the time of each visit.

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

If you have any question regarding the documentation of income or reduced fee program, please call 401-722-0081 and ask for a Family Resource Counselor.

I hereby certify that all information given on this application is correct and completed to the best of my knowledge. Permission is granted for BCVCH to verify any information needed to determine my eligibility. I understand that otherwise, all information is confidential and will only be used in connection with enrollment in the reduced fee program.

Patients Signature: _____ Date: _____

**BVCHC staff to complete below this line**

---

Proof of Income was received and verified: Yes _____ No _____

Initials of employee: _____ Date: _____