Blackstone Valley Community Health Care

Received By:_____
Date Received: _____

Today's Date: _____

Blackstone Valley Community Health Care, Inc. Reduced Fee Application

Blackstone Valley Community Health Care, Inc. (BVCHC) is a non-profit community health center. We receive limited funding from many different sources so that we can provide medical and dental care based on a reduced 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.)	Date of Birth	If applicable, Medical Insurance Carrier and ID number	Monthly Gross Income	Annual Gross Income	**Acct # BVCHC Staff use only**

Guarantor's Name: _____ SS#: _____

Address: _____

Home Number: _____ Cell Number: _____

Email: _____

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 4 paystubs for anyone living in the household over the age of 18.
3. A Letter from employer/person you are working for.
4. We can consider the last few Bank statements provided all the deposits are supported with appropriate documentation.

*Beginning on 1/1/2009, once determined that you are eligible for reduced fees the eligibility is valid through 4/30/2010. New documentation of income must be re-submitted for re-evaluation of eligibility for visits after 5/1/2010.
*New documentation of income must also be re-submitted and re-verified if there is any change in the household size and/or 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.

*There is a $20.00 minimum fee due at time of visit for all patients who qualify for a reduced fee. Please note that this amount may change depending on the services provided to you during your 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 questions regarding the documentation of income or reduced fee program, please call (401) 729-0081 and ask for a Financial Resource Counselor.

"By signing below, I certify all the information given on this application is correct and completed to the best of my knowledge. I give permission for BVCHC to verify any information needed to determine my eligibility. I understand that all information is confidential and will only be used in connection with enrollment in the reduced fee program."

Patients Signature: _____ Date: _____

TO BE COMPLETED BY BVCHC STAFF ONLY

Proof of income was received and verified: Yes_____ No_____

Initials of employee: _____ Date: _____

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