Tri-Area Community Health

Laurel Fork & Stuart 276-398-2292
Ferrum 540-365-4469
Floyd 540-745-9290
Grayson 276-579-1235
Fries and Galax 888-908-4788
www.triareahealth.org

Sliding Fee Program

The Sliding Fee Program allows Tri-Area Community Health (TACH) patients who are uninsured or under-insured to receive healthcare services at a lower cost. We understand it's not always possible for patients to be covered by health insurance, or that your insurance may have high deductibles. TACH offers a Sliding Fee Program to assist patients who may not qualify for public benefits and/or who are not able to afford the full cost of healthcare. An annual grant from the Department of Health & Human Services, Bureau of Primary Health Care provides the resources which enable us to assist patients who may not otherwise be able to afford their medical care and/or medications. The Sliding Fee Program is offered at all TACH sites and applications are processed by staff at each site.

The Slide Program only applies to services provided at the Tri-Area Community Health facilities. Medication discounts apply only to prescriptions written by TACH providers. Slide discounts cannot be used at other doctors, pharmacies, or hospitals.

What Services Are Offered?

- Medical
- Behavioral Health
- X-Ray
- Laboratory
- Pharmaceutical
- Dental

What is Required to Apply?

Complete this application packet
Provide proof of household income or financial assistance - Household is defined as the applicant + spouse/significant other + their legal tax dependents.

Will I Qualify?

Eligibility for the Sliding Fee Program is based on family size and GROSS income (before taxes). See Attached Schedule of Discounts for Income levels.

How Often Do I Need to Apply?

Patients will need to apply for the Sliding Fee Program at least every year. The discounts will typically last 3, 6, or 12 months depending on the patient's unique financial situation. Patients renewing slide eligibility will need to complete a new slide application packet and submit current proof of income before their discount expires. If the discount expires, the patient will have to pay the full charges until a new application packet is processed and approved.

Tri-Area Community Health Sliding Fee Schedule of Discounts

Effective March 3, 2025

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
	$20 Medical & Psychiatry Office Visits (20% cash discount available for paying at time of visit)	**$30 Medical & Psychiatry Office Visits** (20% cash discount available for paying at time of visit)	**$40 Medical & Psychiatry Office Visits** (20% cash discount available for paying at time of visit)	**$50 Medical & Psychiatry Office Visits** (20% cash discount available for paying at time of visit)
	Injection/Vaccination Administration $10*	Injection/Vaccination Administration $12*	Injection/Vaccination Administration $14*	Injection/Vaccination Administration $15*
	Medical Supplies & injectables* *See Separate Fee Schedule	Medical Supplies & injectables* *See Separate Fee Schedule	Medical Supplies & injectables* *See Separate Fee Schedule	Medical Supplies & injectables* *See Separate Fee Schedule
	$10 Behavioral Health Office Visits (cash discount not applicable)	$12 Behavioral Health Office Visits (cash discount not applicable)	$14 Behavioral Health Office Visits (cash discount not applicable)	$15 Behavioral Health Office Visits (cash discount not applicable)
	Pharmacy - Nominal flat fee.	**50% Discount Pharmacy**	**45% Discount Pharmacy**	**40% Discount Pharmacy**
	$10 Dietitian Visit (cash discount does not apply)	$12 Dietitian Visit (cash discount does not apply)	$12 Dietitian Visit (cash discount does not apply)	$12 Dietitian Visit (cash discount does not apply)
	Cana Weight Loss Initial Visit $50 (cash discount applies)	Cana Weight Loss Initial Visit $55 (cash discount applies)	Cana Weight Loss Initial Visit $65 (cash discount applies)	Cana Weight Loss Initial Visit $70 (cash discount applies)
	Cana Weight Loss Follow Up Visit $10 (cash discount not applicable)	Cana Weight Loss Follow Up Visit $15 (cash discount not applicable)	Cana Weight Loss Follow Up Visit $15 (cash discount not applicable)	Cana Weight Loss Follow Up Visit $15 (cash discount not applicable)
	Dental Discounts	**Dental Discounts**	**Dental Discounts**	**Dental Discounts**
	$43 Preventive Office Visit (cash discount not applicable)	$48 Preventive Office Visit (cash discount not applicable)	$53 Preventive Office Visit (cash discount not applicable)	$58 Preventive Office Visit (cash discount not applicable)
	Restorative Services & Extractions - Nominal fees. See schedule. Dental Services by Contracted Dentist -	**54% Discount Restorative Services & Extractions** Dental Services by Contracted Dentist - **See Separate Fee Schedule	**52% Discount Restorative Services & Extractions** Dental Services by Contracted Dentist - **See Separate Fee Schedule	**50% Discount Restorative Services & Extractions** Dental Services by Contracted Dentist - **See Separate Fee Schedule

Tri-Area Community Health Sliding Fee Discount Pay Classes

Effective March 3, 2025

Family Size	LEVEL A		LEVEL B		LEVEL C		LEVEL D	
	0 - 100% FPL		101% - 125% FPL		126% - 150% FPL		151% - 200% FPL	
1	$0.00	$15,650	$15,651	$19,563	$19,564	$23,475	$23,476	$31,300
2	$0.00	$21,150	$21,151	$26,438	$26,439	$31,725	$31,726	$42,300
3	$0.00	$26,650	$26,651	$33,313	$33,314	$39,975	$39,976	$53,300
4	$0.00	$32,150	$32,151	$40,188	$40,189	$48,225	$48,226	$64,300
5	$0.00	$37,650	$37,651	$47,063	$47,064	$56,475	$56,476	$75,300
6	$0.00	$43,150	$43,151	$53,938	$53,939	$64,725	$64,726	$86,300
7	$0.00	$48,650	$48,651	$60,813	$60,814	$72,975	$72,976	$97,300
8	$0.00	$54,150	$54,151	$67,688	$67,689	$81,225	$81,226	$108,300

For families with more than 8 persons, add $5,500 for each additional person.

Based on 2025 Federal Poverty Guidelines (FPL)

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Sliding Fee Program Application

1. Applicant Information

Office location: ❑ Laurel Fork ❑ Ferrum ❑ Floyd ❑ Grayson ❑ Stuart ❑ Galax Schools ❑ Fries **Is this your:** ❑ 1st Time Application ❑ Renewal Application

Name of Responsible Party _____ Date of Birth _____

Address _____ SSN _____

City, State _____ Zip _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow/Widower

Employer _____ Employer's Address _____

2. Household Members

Household = Spouse/Significant Other + Tax Dependents

Name (First Last)	Relationship	Date of Birth	SSN	Health Insurance ☑ or ☒	Pharmacy Insurance ☑ or ☒	Patient at Tri-Area ☑ or ☒	TAX Dependent ☑ or ☒

3. Household Income

Household = Spouse/Significant Other + Tax Dependents

Monthly/Annual Income	**YOU** (the Applicant)	Spouse/ Significant Other/ Partner	Children (over 18)	Others (Must be tax dependents)
NAME OF EMPLOYER AND EMPLOYER'S ADDRESS				
GROSS Wages, Salaries & Tips	$	$	$	$
Self Employment or Stmnt from Employer	$	$	$	$
Social Security & Disability	$	$	$	$
Self Declaration of Income	$	$	$	$
Workers Comp Benefits	$	$	$	$
Child Support & Alimony	$	$	$	$
Savings, Interest Income, Pensions	$	$	$	$
Rental Property, Stocks, Dividends, Other	$	$	$	$
TOTAL	$	$	$	$

4. Eligibility Information

Do you receive food stamps? ❑ yes ❑ no

Do you receive any public assistance? ❑ yes ❑ no

Did you file a tax return last year? ❑ yes ❑ no

Have you applied for Medicaid? ❑ yes ❑ no

Have you applied for Disability? ❑ yes ❑ no

Do you consider yourself homeless? ❑ yes ❑ no

Do you have health insurance? If so, what kind _____

How much is your Deductible? _____ Do you receive child support or alimony? ❑ yes ❑ no

5. Required Proof of Income

Attach all items listed below to this application

❑ **PHOTO ID** - a copy of your drivers license or other photo identification.

❑ **PAYSTUBS** - last/previous months paystubs of everyone working in the household OR a "Statement of Income from Employer" form from your employer with GROSS earnings for the previous month.

❑ **SELF-EMPLOYED** - complete/sign/date a "Self-Employed Statement" form **AND** make sure to include your Schedule C from your most recent tax return.

❑ **BENEFITS/INVESTMENTS/OTHER INCOME** - copies of any benefits checks and/or bank statements for all Investments, Social Security, Disability, Veterans Benefits, Unemployment, Child Support, Alimony, TANF/AFDC, Military LES, Pensions, Interest payments, etc.

❑ **TAX RETURN** - all pages of your most recent tax return. If no return available, sign form 4506T.

❑ **ZERO INCOME** - applicants with ZERO income must complete/sign/date a "Zero Income/Statement of Personal Assistance" form. If you are living off of savings, will need a copy of your bank or savings account statement.

❑ **RELEASE OF INFO/INCOME VERIFICATION** - if receiving public assistance or you have no/limited income, then complete/sign/date the "Release of Info/Income Verification from the DSS" form.

If the application is missing any of the above information or is not signed, it will be denied.

6. Patient Agreement

I certify that all statements contained herein are true and correct and subject to investigation. I authorize the release of employment records and other financial information to an agent of TACH for sliding fee determination purposes. I understand the following:

- I am responsible for payment of all my copays at the time of service.
- I will notify TACH of any changes to my income, household size or insurance status.
- I must renew my application to continue receiving the slide discount (at least annually—more if requested).
- Most routine services are covered under the slide discount. Some procedures, labs, injections and pharmaceuticals are discounted on a separate schedule.
- I understand that if I do not have pharmacy insurance, I may be eligible for pharmacy assistance programs. If eligible, my signature authorizes TACH to share medical, eligibility and financial information with RXPartnership and/or other pharmaceutical companies or their designees as required for eligibility or audit purposes.

Applicant's Signature: _____ Date: _____

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Sliding Fee Program

Self Employed Statement of Income

(Complete this form only if you are self-employed)

Business Name: _____

Business Owner(s): _____

Business Address: _____

_____

Business Phone: _____

Brief Description of Business: _____

_____

_____

GROSS Earnings (FOR THE BUSINESS OWNER = what you paid yourself, *NOT* the business gross)

Need Past (3) Months. Complete below.

Month 20	**Month** 20	**Month** 20
Week 1 $	Week 1 $	Week 1 $
Week 2 $	Week 2 $	Week 2 $
Week 3 $	Week 3 $	Week 3 $
Week 4 $	Week 4 $	Week 4 $
Week 5 $	Week 5 $	Week 5 $
Monthly Total $	**Monthly Total $**	**Monthly Total $**

_____ / _____

Signature of Business Owner Date

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Sliding Fee Program

Statement of Income from Employer

(Have your Employer complete this form)

To Whom It May Concern:

Your employee, (applicant's name) _____, is applying for our Sliding Fee Program (to help with medical expenses) . In order to process his/her application, we must have proof of their last/previous month's gross income.

Therefore, please advise us of how much he/she makes per hour, and approximately how many hours he/she works per week.

$_____ per hour x _____ hours per week (approximately)

OR, if the above isn't practical for your type of business, then please complete the following:

GROSS EARNINGS for last/previous month:

Month: _____ 20____ $_____

Name of Employer: _____

Direct Supervisor: _____

Address: _____

Phone: _____

_____/_____

Employer's signature Date

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Sliding Fee Program

ZERO Income - *Self Declaration of Income*

I, _____, certify that I have NO source of income.

Name of last employer _____ Date of last employment _____

Household/Family Size: _____ **HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents**

I am currently:

- ❑ Unemployed – looking for employment. Not receiving unemployment benefits.
- ❑ Seeking Disability. If so, when did you last apply _____? Have you been denied? _____
- ❑ Other _____

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Tri-Area Community Health for sliding fee determination purposes.

Signed: _____ Date: _____

Instructions: If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors.

Statement of Personal Assistance

I, _____, assist _____ (patient) by providing basic living needs listed below:

Food: ❑ Yes ❑ No Relationship to Applicant: _____
Shelter: ❑ Yes ❑ No
Utilities: ❑ Yes ❑ No
Money: ❑ Yes ❑ No Amount $_____

I can be reached to verify this information at:

My Name (Please print): _____
Address: _____
_____
Phone: _____

Signed: _____ Date: _____

Please list any special circumstances on the back of this form

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Sliding Fee Program

Authorization for Release of Information/ Income Verification from DSS Public Assistance

Applicant's Name (Last, First, Middle Initial) _____

Date of Birth _____ SSN# _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Email _____

County/City of Residence _____

I hereby authorize The Department of Social Services to release information from my file as indicated below to:

TACH @ Laurel Fork & Stuart
ATTN: Sliding Fee Program
PO Box 9, Laurel Fork VA 24352
276-398-2292
276-398-3331 FAX

TACH @ Grayson
ATTN: Sliding Fee Program
6436 Troutdale Highway , Troutdale VA 24378
866-942-0401
276-398-3331 FAX

TACH @ Ferrum
ATTN: Sliding Fee Program
PO Box 159, Ferrum VA 24088
540-365-4469
276-398-3331 FAX

TACH @ Floyd
ATTN: Sliding Fee Program
PO Box 835, Floyd VA 24091
540-745-9290
276-398-3331 FAX

TACH @ Fries
ATTN: Sliding Fee Program
109 Carroll Drive, Fries VA 24330
888-908-4788
276-398-3331 FAX

INFORMATION TO BE RELEASED:

- ☑ Notice of Action
- ☑ Most recent Income Verification
- ☑ SNAP/TANF/WIC/Energy Assistance/etc
- ☑ Other Any other public assistance programs

AUTHORIZATION:

I am applying for the Sliding Fee Program at Tri-Area Community Health and understand TACH needs my income/public assistance verification from the Department of Social Services. Therefore, I authorize the above organizations to communicate freely between one another for the purpose of income/assistance verification. I understand this authorization will be valid for 12 months from the date signed. I understand that I may cancel this authorization by sending a written request for cancellation to TACH, and the cancellation will take effect when TACH receives my written notice.

_____ _____

Signature of Applicant/Patient Date

FOR OFFICE USE ONLY

Faxed ____/____/____

Form **4506-T**
(June 2023)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ► _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

12 / 31 / 23	/ /	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

► _____ _____
Signature (see instructions) Date

► _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

► _____ _____
Spouse's signature Date