**PORTSMOUTH COMMUNITY HEALTH CENTER, INC.**

**dba HAMPTON ROADS COMMUNITY HEALTH CENTER**

**VERIFICATION OF INCOME FOR SLIDING FEE ELIGIBILITY**

* **Form 1040** US Individual Income Tax Return for prior calendar year
* **SSA-Award letter** Social Security Benefit Statement **if not required to file an income tax return**
* **Social Services** Notice of Action for Food Stamp Allotment that shows Gross Monthly Income
* **VEC W6** will be accepted ***TEMPORARILY*** until one of the above forms is available. W6 forms must be updated every 3 months.

Your co-pay/nominal fee will be determined by your proof of income and family household as set by the Health & Human Services Poverty Guidelines and will fall into one of the following categories:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Category*** | ***Income as Percent of Poverty Level*** | ***Nominal Fee MEDICAL*** | ***Nominal Fee DENTAL*** | ***Nominal Fee***  ***BEHAVIOR HEALTH*** |
| **A** | **100% and below** | **$25**  **\*\*Lab fee is separate\*\*** | **$67 Comprehensive exam and x-ray**  **Emergency at $112**  **Preventive dental visit $55**  **(Must have current exam)** | **$10** |
|  |  | ***Co-pay MEDICAL*** | ***Co-pay DENTAL*** | ***Nominal Fee***  ***BEHAVIOR HEALTH*** |
| **B** | **Greater than 100% up to 125%** | **$35**  **\*\*Lab fee is separate\*\*** | **$89 Comprehensive exam and x-ray**  **Emergency at 51% of cost** | **$10** |
| **C** | **Greater than 125% up to 150%** | **$45**  **\*\*Lab fee is separate\*\*** | **$111 Comprehensive exam and x-ray**  **Emergency at 61% of cost** | **$10** |
| **D** | **Greater than 150% up to 175%** | **$55**  **\*\*Lab fee is separate\*\*** | **$133 Comprehensive exam and x-ray**  **Emergency at $71% of cost** | **$10** |
| **E** | **Greater than 175% up to 200%** | **$65**  **\*\*Lab fee is separate\*\*** | **$155 Comprehensive exam and x-ray**  **Emergency at 81% of cost** | **$10** |
| **Add’l Fee** | **n/a** | **n/a** | **$45 - $55 per tooth**  **same area of extractions** | **n/a** |
| **Other** | **n/a** | **n/a** | **Full & Partial Dentures also available at a reduced rate** | **n/a** |

Total Qualifying Income \_\_\_\_\_\_\_\_\_\_\_\_\_

Family Size \_\_\_\_\_

Category\_\_\_\_\_\_\_ and medical co-pay $\_\_\_\_\_\_\_\_\_\_ Dental copay/deposit of $\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

(copay) (deposit)

I agree the above information is true and accurate to the best of my knowledge and accept the services of Portsmouth Community Health Center, Inc. (PCHC) based on the above. If the information above has been given falsely with the intent to defraud, I realize that Portsmouth Community Health Center, Inc. has the right to take appropriate action to recover any charges that may occur as a result of giving false information. Any changes to income and/or family size are to be reported immediately. **Re-verification is due \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, pending no changes.**

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Interviewer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_