Battenkill Valley Health Center
Application for Sliding Fee Program

*** Return to the office with proof of income and proof of physical address ***

1. Applicant - Head of Household

Name (Last) (First) (MI)

Physical Address City State Zip

Preferred Phone Date of Birth

2. Household Members (Include spouse/partner, dependent children, relatives, & others that live with you 50% of the time)

Name	Relationship	Birth Date
1.		
2.		
3.		
4.		
5.		

Have you applied for State Healthcare? ☐ Y ☐ N Results of application:

Are you a College/University student? ☐ Y ☐ N Are you a tourist or foreign student? ☐ Y ☐ N

Can you be claimed as a dependent on someone else's tax return? ☐ Y ☐ N *(If yes, additional income verification is required)*

3. Household Income (Include all members of your household who have income)

Total Household Members:

Wages/salary for all $ per not applicable

Self-employment income for all $ per not applicable

Unearned sources of income for all $ per not applicable

Total Annual Income $

4. Insurance

Do you or your spouse have medical insurance benefits? ☐ Y ☐ N

5. Signature

To the best of my knowledge, the above information is true and correct. I agree to inform BVHC of any changes in employment, household size, household income, insurance status or financial status for anyone listed on this application. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated. I also give permission for the BVHC staff to contact my employer or any other source to verify income.

_____

Signature of Applicant Date

FOR BVHC USE ONLY

Authorizer Initials _____ Fee Level _____ Approval/Denial _____ Date _____ Expiration Date _____