Account #: «AccountNumber»

Return Application by: _____

DISCOUNT PROGRAM APPLICATION

APPLICANT INFORMATION

Last Name:	First Name:		Middle Initial:
Mailing/Street Address:	City:	State:	Zip Code:
Phone #:	Social Security:		Date of Birth:
County you live in:			# in Household:
Insurance (if any):	Medicaid	None	
	Medicare	Other (specify)	

HOUSEHOLD INFORMATION (List all in household, related by blood/marriage/adoption & financially responsible for each other.)

Last Name	First Name	Social Security #	Date of Birth	Relationship to Applicant	Also Applying Yes
				Self	

*Please checkmark here if additional individuals are listed on back . ☐

TYPE OF INCOME RECEIVED BY HOUSEHOLD

Source	You Yes		Spouse/ Partner		Other		Total	How many ti Monthl	Per
Salary/Self Employment									
Unemployment									
Social Security/Disability									
Pensions/Annuities/Other									

DISCOUNT PROGRAM APPLICANT AGREEMENT

- I understand my discount percentage may change upon final review of my application.
- I understand I must provide acceptable proof of income for each person listed on this application.
- I understand it is my responsibility to notify Valley Health of any changes in above information provided.
- I understand I must renew my application eachyear- with proof of income to remain an active participant.
- I have read additional terms of the Sliding Fee Discount Program Policy, and agree to each.

I hereby certify that the information provided on this application is accurate and I authorize Valley Health

Systems to verify any of the information provided above.

REQUIRED: Signature of Applicant:_____ Date: _____

RETURN COMPLETED APPLICATION WITH DOCUMENTATION TO YOUR VALLEY HEALTH CENTER OR TO THIS ADDRESS:

Valley Health-Business Office; Attn: Sliding Fee Coordinator * 5636 Route 60, Suite 1B* Huntington, WV 25705


VALLEYHEALTH
Quality healthcare in your neighborhood.


Care
Connect
Valley Health's Chronic Care Management program


VALLEYHEALTHPHARMACY
Quality Healthcare...Beyond the Exam Room