



Eastern Shore Rural Health System, Inc. Sliding Fee Application

Proof of income is required to process this application.

Corporate Office
20280 Market Street
Onancock, VA 23417
757-414-0400
Fax 757-414-0569
Billing 757-414-0431
www.esrh.org
E-mail: info@esrh.org

Name: _____ Date of Birth: _____

Mailing Address: _____ City/State: _____

Zip: _____ Telephone #: _____ Cell Phone #: _____

Social Security Number _____

Name of Medical Insurance _____ Dental insurance: _____

Do you or anyone listed on this application have any of the following? (Please circle.) If yes, attach proof.

Atlantic Community Health Center
Dental Services Provided
5219 Lankford Highway
P.O. Box 130
New Church, VA 23415
757-824-5872
Fax 757-824-5872

- | | | | |
|-----------------|----------------|--------------------|--------------------|
| Medicaid | Medicare | Famis Medicaid | NET Business |
| Social Security | SSI | Unemployment | Rental Income |
| ADC | General Relief | Alimony | Military Allotment |
| Child Support | Disability | Family Support | Dividends |
| SNAP Benefits | Interest | Pension/Retirement | Other |

Chincoteague Island Community Health Center
4049 Main Street
Chincoteague Island, VA 23336
757-336-3682
Fax 757-336-3703

Employer: _____ Work #: _____
Pay cycle ___ Weekly ___ 2 Wks ___ 2 Monthly ___ Monthly ___ Other

Eastville Community Health Center
Dental Services Provided
17068 Lankford Highway
P.O. Box 98
Eastville, VA 23347
757-331-1086
Fax 757-442-9505

Employer: _____ Work #: _____
Pay cycle ___ Weekly ___ 2 Wks ___ 2 Monthly ___ Monthly ___ Other

Household Wages: _____ Number of persons supported by this income: _____

Franktown Community Health Center
Dental Services Only
9159 Franktown Road
P.O. Box 9
Franktown, VA 23354
757-442-4819
Fax 757-442-2264

| Dependent Family Members: | Date of Birth: | Relationship to Applicant: |
|---------------------------|----------------|----------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Onley Community Health Center
20306 Badger Lane
P.O. Box 159
Onley, VA 23418
757-787-7374
Fax 757-787-4513

I certify that the above information is true. I have read and understand the sliding fee benefit information on the back of this form. The only income I have is correctly stated above. If any changes occur I will immediately notify the billing office.

Signature: _____ Date _____

Metompkin Elementary School Dental Program
757-665-1159

Office Use Only
Total Annual Income _____ SF Type _____ Account #: _____

Nandua Middle School Dental Program
757-787-3494

Interviewer: _____ Date: _____

Pungoteague Elementary School Dental Program
757-789-7777

**Please read and sign this form and return it to one of our centers.
Please see reverse side.**

Eastern Shore Rural Health offers a sliding fee or discount due to a government program. Below is a brief summary explaining your benefits. Please read the following information. If you have questions or concerns, please feel free to ask us.

Your income and family size determine your discount. If there are any changes to your income or family size, please contact our office.

What you will pay per visit:

Medical visits: \$20.00, \$30.00, \$35.00 or \$40.00.

Pediatric medical visits provided by ESRHS providers at Riverside Shore Memorial Hospital: \$50.00, \$75.00, \$90.00 or \$100.00.

Dental: \$35.00, \$50.00, \$55.00 or \$65.00.

Sliding fee may be approved for up to one year at a time.

Your discount is valid at Atlantic, Eastville, Chincoteague, Franktown, Onley Community Health Centers, Metompkin Elementary School Dental, Nandua School Dental and Pungoteague Elementary School Dental.

One month before your sliding fee expires; **you will need** to contact our office to complete a new application and provide your current POI.

The following can be turned in as proof of Income. We may request additional information for proof of income.

- Most recent tax return
 - Most recent check stub (2 are required)
 - Monthly Retirement
 - Monthly Disability (Can obtain a print out from Disability Office)
 - Medicaid or Famis for the person applying
 - Monthly Social Security (Can obtain a print out from Social Security Office)
 - Monthly assistance such as food stamps (Can obtain a print out from Social Services)
 - Letter from person helping with monthly support (signed and dated)
- Please call if there are questions about other possibilities.

YOU MUST PAY YOUR COPAY AT THE TIME OF YOUR VISIT.

By signing below, you give ESRH permission to share this information with other health care agencies to which you may be referred, that also offer discount programs.

Name _____ Date _____