

Bland County Medical Clinic, Inc.

12301 Grapefield Road
Bastian, VA 24314

Form A

Healthy Neighborhood Health Plan – Reduced Fee Status

STATEMENT OF UNDERSTANDING

BCMC OFFICE USE ONLY
ACCOUNT # _____

Proof of Income _____ Other _____

The information I have provided concerning the size of my family and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge.

I have given this information concerning my financial situation and my means and ability to pay for the purpose of procuring for my own and my families benefit the discount of my accounts with Bland County Medical Clinic, Inc. (BCMC). I understand BCMC will rely on such information to determine applicable discount rate for my account.

I understand that knowingly giving false information in this case may result in criminal prosecution under the laws of the State of Virginia.

I agree to report any change in either my income for my family size to BCMC before or at the time of my next contact or any contact by any member with BCMC. I know that the information I have given will continue to be relied upon until it is changed.

I understand that my discount status will be reviewed on an annual basis and adjusted according to my family income and size at the time of review. If BCMC has reason to suspect that the information I have given is untrue, inaccurate, or that I have not properly reported changes, BCMC may initiate a review of my status and I will authorize access to all my financial records. If I refuse an authorization, BCMC will no longer discount my account.

My signature below indicates that all information I have provided is true to the best of my knowledge. I also am stating that I have no health insurance coverage to pay for any or all of the services I have or will be receiving.

Signature (Applicant/Head of Household)

Date

Bland County Medical Clinic, Inc.
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Form B

Healthy Neighborhood Health Plan
APPLICATION FOR REDUCED FEE STATUS

Name of Applicant _____ Name of Spouse _____

Address _____

Phone # _____

Employer _____ Employer _____

Employer Address _____ Employer Address _____

List Additional Family Members

1. _____ 2. _____ 3. _____ 4. _____

Insurance Information (covered family members)

Policy #	Policy Holder	Relationship
	Medicaid	Blue Cross/Blue Shield
	Medicare	Other
Covered Family Members:		
1 _____	2 _____	
3 _____	4 _____	

I hereby authorize the investigation of all statements contained herein and authorize the release of all employment records and other financial information to an agent of Bland County Medical Clinic, Inc.

Signature (Head of Household)

FAMILY INCOME DETERMINATION WORKSHEET

Family Size _____

Head of Household Social Security Number _____

<u>Income Source</u>	<u>Income</u>	<u>Income Source</u>	<u>Income</u>
Wages (Head and Household)	_____	Pensions/Annuities	_____
Personal Business Profits	_____	Welfare Payments	_____
Farm Income	_____	Aid To Dependent Child	_____
Seasonal Income	_____	Alimony	_____
Disability Income	_____	Child Support	_____
Unemployment Benefits	_____	Veteran's Benefits	_____
Social Security Benefits	_____	Other (please specify/includes interest, dividends)	_____

TOTAL ANNUAL GROSS INCOME _____

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Healthy Neighborhood Health Plan

Office Use Only

Determination of Reduced Fee Status

After careful examination of the applicant's family size and financial situation it is my determination this application for reduced fee status be:

Granted

Denied

Reduced Fee Status Classification:

A

B

C

D

E

This status will remain in effect for one (1) year from this date at which time the applicant's financial situation will be reviewed to reevaluate eligibility and classification.

Expiration Date: _____

Authorized Signature: _____

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Form C

Proof Of No Income

1. Statement from Virginia Employment Commission approving or denying employment compensation. Review the situation in ninety days or at next clinic visit, whichever comes first. If unemployment compensation is denied, proof of how patient is supporting himself or herself. We must have a statement from the person providing lodging and food for the patient.
2. Termination notice from previous employer.
3. Layoff notice from employer.
4. Statement from person supplying food and shelter.
5. If no income at time of financial eligibility screening, family will be designated as Income A, and financial screening is to be done again in ninety (90) days or at next clinic visit, whichever comes first. Explain in "Remarks" how family is supporting itself, e.g. savings, loans, etc.
6. Proof of Medicaid or welfare cancellation.

Other Income

Unusual situations not previously described should be documented in the "Remarks" section of the CHS-1 and submitted to the bureau central office for approval before providing any service.