



HealthWorks for Northern Virginia
Your Community Health Center

Quality Healthcare for All

Sliding Fee Discount Application

It is the policy of HealthWorks for Northern Virginia to provide essential services regardless of the patient’s ability to pay. Sliding fees are offered based on family or household size and annual income. Household is defined as the head of the household, spouse or significant other, children under 18, parents, grandparents and adult children if applicable. Please complete the requested information to determine if you or members of your family/household are eligible for discounted fees. Additional fees may apply at the end of the visit if the patient has received additional services, such as lab tests, procedures, supplies and equipment, shots or vaccinations.

Head of Household (1)			
Last Name:	First:	Middle:	Home Phone Number: ()
Street Address:			Cell Phone Number: ()
City:	State:	Zip Code:	Date of Birth: / /
Head of Household (2)			
Last Name:	First:	Middle:	Home Phone Number: ()
Street Address:			Cell Phone Number: ()
City:	State:	Zip Code:	Date of Birth: / /
All Household Dependents			
Name		Date of Birth	
1.		/ /	
2.		/ /	
3.		/ /	
Name		Date of Birth	
4.		/ /	
5.		/ /	
6.		/ /	

✓ I certify that the family size and income verification I have provided is correct.

Head of Household (1)	Head of Household (2)
Signature:	Signature:
Date:	Date:



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OFFICE USE ONLY

Annual Household Income				
Source of Income	Self - Head of Household (1)	Head of Household (2)	Other	Total
Gross wages, salaries, tips Income from business, self-employment, day labor				
Income from dependents/others, unemployment compensation, workers compensation, SSI, Social Security, Public Assistance, Food Stamps, TANF, pension or retirement				
Interest, dividends, rents, alimony, child support, and miscellaneous sources				
Total Annual Income				

Verification Checklist	Yes	No
Identification/Address: Driver's License, utility bill, employment ID, other		
Income: two most recent pay stubs, tax return, employer statement, other		
Insurance: Insurance card(s)		

Approved By (Print Name): _____

Date: _____