Floyd

Tri-Area Community Health Centers

(http://triareahealth.org/)

Patient Portal (https://mycw77.ecwcloud.com/portal10058/jsp/100mp/login.jsp)

(https://www.facebook.com/triareahealth/) (mailto:comments@triareahealth.org)

Donate (http://triareahealth.org/donate/)

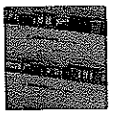
Welcome! We are so happy that you have chosen Tri-Area Community Health as your primary care home. Our staff consists of highly qualified physicians and a team of highly qualified clinical and support professionals working together to provide the highest quality of care. We look forward to providing all of your primary care needs.

Getting Started:

1. Schedule an Appointment
   - Select one of our convenient locations: Laurel Fork, Ferrum, or Floyd (http://triareahealth.org/locations/)
   - Call to make your appointment or use our convenient online form (http://triareahealth.org/patients/appointments/)
2. Prepare for Your First Appointment:
   - Be sure to bring along any medication you are currently taking.
   - To save time, please complete all of these forms and bring them with you to your first appointment. (http://triareahealth.org/patients/forms/)
   - If you are transferring your medical records, please complete the "Release of Medical Records" form and send it to your previous provider so that we will have access to your medical records.
   - If you are applying to our Sliding Scale Program, bring along ALL of your proof of income information so there is no delay in approving your application.

News & Events

Brittany Butler, PA says Farewell to Tri-Area
June 27, 2017



Tri-Area Community Health Expands CHC Site at Ferrum
March 29, 2017

UPCOMING EVENTS

Patrick County Ag. Fair (http://triareahealth.org/event/patrick-county-ag-fair/)

September 19 - September 22

View All Events (http://triareahealth.org/events/)

Tri-Area Community Health

www.triareahealth.org

Authorization for Release of Protected Health Information

Patient Name (Last, First, Middle Initial) _____ Maiden or Other Name _____

Date of Birth _____ SSN# _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Email _____

☐ **I hereby authorize** _____ (print name of provider) **to release information from my file as indicated below to:**

Tri-Area Community Health
Send all correspondence to:
PO Box 9
Laurel Fork, 24352
Fax: 276-398-3331

☐ **I hereby authorize Tri-Area Community Health to release information from my medical record as indicated below to:**

_____

INFORMATION TO BE RELEASED:

	DATES
❑ History and Physical Exam	_____
❑ Progress Notes	_____
❑ Lab Reports	_____
❑ X-ray Reports	_____
❑ Other _____	_____

I specifically authorize the release of information relating to:

- ❑ Substance Abuse (including alcohol/drug abuse)
- ❑ Mental Health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

Purpose of release:

- ❑ Continuation/Coordination of Care, follow-up treatment or ongoing care
- ❑ Other _____

AUTHORIZATION:

- I understand this authorization will expire (90) days after I have signed this form.
- I understand I may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified except to the extent action has already been taken.
- I understand information used or disclosed pursuant to this authorization my be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations
- I understand that while there is usually no charge for medical records if copies are sent for ongoing care or follow up treatment, **some facilities charge for transfer of records. The patient is responsible for any charges related to the transfer of records.**

_____ _____
Signature of Patient/Legal Guardian Date

Tri-Area Community Health Centers

Payment Policy

Payments

Payment is due at the time of service. Co-pays cannot be waived. We accept cash, checks, bank cards, money orders, MasterCard, Visa, and Discover.

Insurance

We will submit claims to most major insurance carriers including Medicare and Virginia Medicaid. Please bring your insurance card with you to every visit so that we can ensure that our records are accurate.

If your insurance requires a referral or prior-authorization for you to be seen at Tri-Area Community Health, it is your responsibility to obtain prior to your visit. If not obtained, you will be responsible for the charges.

Specific questions regarding insurance coverage should be addressed by your carrier, or our business office may be able to assist you.

No Show Policy

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. If it is necessary for you to reschedule or cancel your appointment, please call us at least 24 hours prior to your scheduled appointment.

If you arrive after your scheduled appointment, you may be asked to reschedule your appointment, in order to accommodate patients that have arrived on time.

Patients with repeated no shows and last minute cancellations will be placed on an alternative appointment scheduling program. If placed on the alternative appointment scheduling program, patients may only schedule "same day" appointments as available and will not be allowed to pre-schedule appointments.

Tri-Area Community Health _____ LF _____ Floyd _____ Ferrum

Patient Registration Form

Please print clearly your response to all requested information. If you have questions, please ask. THANK YOU!!!

Where did you hear about Tri-Area ◇ College ◇ Community ◇ Family/Fr
◇ Health Dept/Social ◇ Newspaper ◇ Other _____

Patient Information

Patient's Full Name: _____ Sex at birth: M F
(FIRST) (MIDDLE) (LAST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____ Work: ( )_____-_____ DOB: ____/____/____(mm/dd/yyyy)

Email Address: _____ Cell: ( )_____-_____ Are you a veteran? (circle one) Yes No

Social Security #: ____/____/____ Marital Status: (circle one) S M D W (Single/Married/Divorced/Widowed) Age: _____

Employer: _____ Phone No: ( )_____-_____

Employer's Address: _____
(STREET) (CITY) (STATE) (ZIP)

Responsible Party Information ___ Yourself ___Spouse ____Parent ___ Other

Name: _____
(FIRST) (MIDDLE) (LAST)

Physical Address: _____
(STREET) (CITY) (STATE) (ZIP)

Mailing Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____ Work: ( )_____-_____ DOB: ____/____/____(mm/dd/yyyy)

Employer: _____ Phone No: ( )_____-_____

Employer's Address: _____
(STREET) (CITY) (STATE) (ZIP)

Insurance Information

Who is the insurance policy holder?: (circle one) Self Spouse Parent - Mother or Father

Name of Policy Holder: _____
(FIRST) (MIDDLE) (LAST)

Social Security # or Policy ID#: _____ Policy Holder DOB: _____

Emergency Contact

Emergency contact other than spouse: _____ Relationship to you: _____
(FIRST) (MIDDLE) (LAST)

Home Phone: ( )_____-_____ Work Phone: ( )_____-_____

PREFERRED PHARMACY: _____
City _____ Phone number _____

(Form continues on back)

The following information is for public health service grant purposes only. No personally identifiable information is ever reported. By providing this information, you help us continue to receive funding to provide services to the community and special populations. Please circle answers below.

RACE: White Black/African American Asian Pacific Islander American Indian

More than one race

Ethnicity: Are you Hispanic or Latino? Yes No

Preferred Language: English Spanish Other ____ Is an interpreter needed? Yes No

Is your main source of work for you or your family seasonal or migrant work? Yes No

Are you homeless? Yes No

If yes, where do you sleep at night? Shelter Street Stay with a friend Other

Annual household income (please circle one below). **Number of people in household** ____

0-$10,000	$25,000-29,999	$50,000-59,999	
$10,000-14,999	$30,000-34,999	$60,000-69,999	**Choose not to disclose**
$15,000-19,999	$35,000-39,999	$70,000-79,999	
$20,000-24,999	$40,000-49,999	$80,000-above	

Current gender: Male Female Other **Choose not to disclose**

Transgender: Male to Female Female to Male

Sexual Orientation: Straight Lesbian or Gay Bisexual **Choose not to Disclose**

Don't know Other

Form continues to page 3

AUTHORIZATIONS AND CERTIFICATIONS

I HEREBY AUTHORIZE THE FOLLOWING:

- ***Tri-Area Community Health*** **through its appropriate personnel and/or its medical staff to perform, administer, prescribe, or to have performed, administered, or prescribed upon, to, or for me or any members of my family (including minor children) whose names appear below, such examination, tests, immunizations, injections, and diagnostic procedures as are deemed necessary. I also certify that all information contained herein is true and correct to the best of my knowledge and belief, and that no facts have been omitted.**

- ***Insurance Authorization and Assignment*** **to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.**

- ***Medicare Lifetime Authorization*** **for physical services and request that payment of authorized Medicare benefits to make either to me or on my behalf to Tri-Area Community Health, Inc., d.b.a. Tri-Area Community Health, for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

- ***Deemed Consent for Designated Blood borne Pathogens:***
  Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS virus) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.
  Under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Tri-Area Community Health is directly exposed to body fluids of a patient in a manner which may transmit HIV (AIDS virus) or Hepatitis B and C according to the guidelines of the Centers for Disease Control, Tri-Area Community Health will proceed to test the patient's blood for HIV and Hepatitis B and C. Tri-Area Community Health will provide the results of the test to the patient through his or her primary care provider, and to the health care worker who was exposed. Tri-Area Community Health's policy also protects you as a patient, should you be exposed to the body fluids of a health care worker.

- ***I ALSO CERTIFY*** **that I have read and understand the collection policy of Tri-Area Community Health and agree to abide by it._____(initials)**

- ***I ALSO CERTIFY*** **that I have read and understand the No Show Policy of Tri-Area Community Health and agree to abide by it._____(initials)**

THE INFORMATION PROVIDED ON THIS REGISTRATION FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:_____ **DATE:**_____

Tri-Area Community Health

Privacy Officer
P.O. Box 9, Laurel Fork, VA 24352
Phone: 276-398-2292

Your information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights

➢ **See page 2** for more information on these rights and how to exercise them.

Your Choices

You have some choices in the way that we use and share your information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ **See page 3** for more information on these choices and how to exercise them.

Our uses and disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other governmental requests
- Respond to lawsuits and legal actions

➢ **See pages 3 and 4** for more information on these uses and disclosures.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site www.triareahealth.org.

Tri-Area Community Health Centers

Ferrum, Floyd and Laurel Fork

P. O. Box 9
Laurel Fork, VA 24352
276-398-2292 Phone
276-398-3331 Fax

AUTHORIZATION FOR PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby give my permission to the person(s) listed below to receive information about my care:

NAME	RELATIONSHIP	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
Signature of Patient, Parent or Guardian

_____
Relationship to Patient

_____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the
(Please Print Patient Name)

Notice of Privacy Practices from Tri-Area Community Health, Inc. at

Laurel Fork, Ferrum, and Floyd.

Signature: _____ Date: _____

OR

in lieu of patient signature, I, _____,
(Please Print Your Name)

a staff member of Tri-Area Community Health state that

_____ has been given our
(Please Print Patient Name)

current Notice of Privacy Practices.

Signature: _____ Date: _____

(FILE IN PATIENT MEDICAL RECORD)

Tri-Area Community Health

Laurel Fork 276-398-2292
Ferrum 540-365-4469
Floyd 540-745-9290
Fax 276-398-3331

Sliding Fee Program

The sliding fee program allows Tri-Area Community Health (TACH) patients who are uninsured or under-insured to receive healthcare services at a lower cost. We understand it's not always possible for patients to be covered by health insurance, or that insurance may have high deductibles. TACH offers a sliding fee program to assist patients who may not qualify for public benefits and/or who are not able to afford the full cost of healthcare. An annual grant from the Department of Health & Human Services, Bureau of Primary Health Care provides the resources which enable us to assist patients who may not otherwise be able to afford their medical care and medications. The sliding fee program is offered at all three sites and applications are processed by staff at each site.

The sliding fee program only applies to services provided at the Tri-Area Community Health facilities. Medication discounts apply only to prescriptions written by TACH providers. Slide discounts cannot be used at other doctor offices, pharmacies or hospitals.

What services are offered?

- Medical
- X-ray
- Dental
- Laboratory
- Pharmaceutical
- Behavioral Health

What is required to apply?

- Complete registration packet
- Provide proof of household income or financial assistance
- Household is defined as the applicant + spouse/significant other + their legal tax dependents

How often do I need to apply?

Patients will need to apply for the sliding fee program at least every year. The discounts will typically last 3, 6, or 12 months depending on the patient's unique financial situation. Patients renewing sliding scale eligibility will need to complete a new slide application packet and submit current proof of income before their discount expires. If the discount expires, the patient will have to pay the full charges until a new application packet is processed and approved.

Will I qualify?

See next page for income levels and fees.

Tri-Area Community Health Sliding Fee Schedule of Discounts

Effective February 13, 2017

Family Size	LEVEL A		LEVEL B		LEVEL C		LEVEL D	
	0 - 100% FPL		101% - 125% FPL		126% - 150% FPL		151% - 200% FPL	
1	$0.00	$12,060.00	$12,061.00	$15,075.00	$15,076.00	$18,090.00	$18,091.00	$24,120.00
2	$0.00	$16,240.00	$16,241.00	$20,300.00	$20,301.00	$24,360.00	$24,361.00	$32,480.00
3	$0.00	$20,420.00	$20,421.00	$25,525.00	$25,526.00	$30,630.00	$30,631.00	$40,840.00
4	$0.00	$24,600.00	$24,601.00	$30,750.00	$30,751.00	$36,900.00	$36,901.00	$49,200.00
5	$0.00	$28,780.00	$28,781.00	$35,975.00	$35,976.00	$43,170.00	$43,171.00	$57,560.00
6	$0.00	$32,960.00	$32,961.00	$41,200.00	$41,201.00	$49,440.00	$49,441.00	$65,920.00
7	$0.00	$37,140.00	$37,141.00	$46,425.00	$46,426.00	$55,710.00	$55,711.00	$74,280.00
8	$0.00	$41,320.00	$41,321.00	$51,650.00	$51,651.00	$61,980.00	$61,981.00	$82,640.00

For families with more than 8 persons, add $4,180 for each additional person.

Based on 2017 Federal Poverty Guidelines (FPL)

LEVEL A	LEVEL B	LEVEL C	LEVEL D
$20 Medical & Psychiatry Office Visits (20% cash discount available for paying at time of visit)	**$30 Medical & Psychiatry Office Visits** (20% cash discount available for paying at time of visit)	**$40 Medical & Psychiatry Office Visits** (20% cash discount available for paying at time of visit)	**$50 Medical & Psychiatry Office Visits** (20% cash discount available for paying at time of visit)
Injection/Vaccination Administration $10	Injection/Vaccination Administration $12	Injection/Vaccination Administration $14	Injection/Vaccination Administration $15
Medical Supplies & Injectables* *See Separate Fee Schedule	**Medical Supplies & Injectables*** *See Separate Fee Schedule	**Medical Supplies & Injectables*** *See Separate Fee Schedule	**Medical Supplies & Injectables*** *See Separate Fee Schedule
$10 Behavioral Health Office Visits (cash discount not applicable)	$12 Behavioral Health Office Visits (cash discount not applicable)	$14 Behavioral Health Office Visits (cash discount not applicable)	$15 Behavioral Health Office Visits (cash discount not applicable)
Behavioral Health Assessments Level I - $50, Level II $100 (20% cash discount available for paying at time of visit)	Behavioral Health Assessments Level I - $55 Level II $115 (20% cash discount available for paying at time of visit)	Behavioral Health Assessments Level I - $60 Level II $120 (20% cash discount available for paying at time of visit)	Behavioral Health Assessments Level I - $65 Level II $125 (20% cash discount available for paying at time of visit)
Pharmacy - Flat Nominal fee.	50% Discount Pharmacy	45% Discount Pharmacy	40% Discount Pharmacy
Dental Discounts	**Dental Discounts**	**Dental Discounts**	**Dental Discounts**
$40 Preventive Office (cash discount not applicable)	$45 Preventive Office Visit (cash discount not applicable)	$50 Preventive Office Visit (cash discount not applicable)	$55 Preventive Office Visit (cash discount not applicable)
Restorative Services and Extractions - nominal fees** Dental Services by Contracted Dentist - **See Separate Fee Schedule	52% Discount Restorative Services & Extractions Dental Services by Contracted Dentist - **See Separate Fee Schedule	50% Discount Restorative Services & Extractions Dental Services by Contracted Dentist - **See Separate Fee Schedule	48% Discount Restorative Services & Extractions Dental Services by Contracted Dentist - **See Separate Fee Schedule

Tri-Area Community Health
www.triareahealth.org

Laurel Fork, 276-398-2292
Ferrum, 540-365-4469
Floyd, 540-745-9290

Sliding Fee Program Application

1. Applicant Information

Which office do you go to: ☐ Laurel Fork ☐ Ferrum ☐ Floyd Is this your: ☐ 1st Time Application ☐ Renewal Application

Name of Responsible Party _____ Date of Birth _____

Address _____ SSN _____

City, State _____ Zip _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Employer _____ Employer's Address _____

Do you have health insurance? ☐ yes ☐ no Do you have pharmacy insurance? ☐ yes ☐ no

2. Household Members

Household = Spouse/Significant Other + Tax Dependents

Name (First Last)	Relationship	Date of Birth	SSN	Health Insurance ☑ or ☒	Pharmacy Insurance ☑ or ☒	Patient at Tri-Area ☑ or ☒	TAX Dependent ☑ or ☒

3. Household Income

Household = Spouse/Significant Other + Tax Dependents

Monthly/Annual Income	YOU (the Applicant)	Spouse/ Significant Other/	Children (over 18)	Others (Must be tax
NAME OF EMPLOYER AND EMPLOYER'S ADDRESS				
GROSS Wages, Salaries & Tips	$	$	$	$
Self Employment or Stmnt from Employer	$	$	$	$
Social Security & Disability	$	$	$	$
Self Declaration of Income	$	$	$	$
Workers Comp Benefits	$	$	$	$
Child Support & Alimony	$	$	$	$
Savings, Interest Income, Pensions	$	$	$	$
Rental Property, Stocks, Dividends, Other	$	$	$	$
TOTAL	$	$	$	$

4. Eligibility Information

Do you receive food stamps?	❑ yes ❑ no	Have you applied for Medicaid?	❑ yes ❑ no
Do you receive any public assistance?	❑ yes ❑ no	Have you applied for Disability?	❑ yes ❑ no
Did you file a tax return last year?	❑ yes ❑ no	Do you consider yourself homeless?	❑ yes ❑ no

Do you have health insurance? If so, what kind _____

How much is your Deductible? _____ Do you receive child support or alimony? ❑ yes ❑ no

5. Required Proof of Income *Attach all items listed below to this application*

- ❑ **PHOTO ID** - a copy of your drivers license or other photo identification.
- ❑ **PAYSTUBS** - last/previous months paystubs of everyone working in the household OR a "Statement of Income from Employer" form from your employer with GROSS earnings for the previous month.
- ❑ **SELF-EMPLOYED** - complete/sign/date a "Self-Employed Statement" form **AND** make sure to include your Schedule C from your most recent tax return.
- ❑ **BENEFITS/INVESTMENTS/OTHER INCOME** - copies of any benefits checks and/or bank statements for all Investments, Social Security, Disability, Veterans Benefits, Unemployment, Child Support "Paid or Received", Alimony, TANF/AFDC, Military LES, Pensions, Interest payments, etc.
- ❑ **TAX RETURN** - all pages of your most recent tax return.
- ❑ **ZERO INCOME** - applicants with ZERO income must complete/sign/date a "Zero Income/Statement of Personal Assistance" form. If you are living off of savings, will need a copy of your bank or savings account statement.
- ❑ **RELEASE OF INFO/INCOME VERIFICATION** - if receiving public assistance or you have no/limited income, then complete/sign/date the "Release of Info/Income Verification from the DSS" form.

If the application is missing any of the above information or is not signed, it will be denied.

6. Patient Agreement

I certify that all statements contained herein are true and correct and subject to investigation. I authorize the release of employment records and other financial information to an agent of TACH for sliding fee determination purposes. I understand the following:

- I am responsible for payment of all my copays at the time of service.
- I will notify TACH of any changes to my income, household size or insurance status.
- I must renew my application to continue receiving the slide discount (at least annually—more if requested).
- Most routine services are covered under the slide discount. Some procedures, labs, injections and pharmaceuticals are discounted on a separate schedule.
- I understand that if I do not have pharmacy insurance, I may be eligible for pharmacy assistance programs. If eligible, my signature authorizes TACH to share medical, eligibility and financial information with pharmaceutical companies or their designees as required for eligibility or audit purposes.

Applicant's Signature: _____ Date: _____

Form **4506-T**
(Rev. August 2014)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Tri-Area Community Health, Corporate Office, PO Box 9, Laurel Fork VA 24352 276/398-3331 FAX

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ 1040

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☑

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☑

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution. If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. 12/31/2015 12/31/2016

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Sign Here	▶ **Signature** (see instructions)	**Date**	**Phone number of taxpayer on line 1a or 2a**
	▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
	▶ **Spouse's signature**	**Date**	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its instructions, go to *www.irs.gov/form4506t*. Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note. If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888 559-456-7227
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P. O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party—Business.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

Tri-Area Community Health
www.triareahealth.org

Laurel Fork, 276-398-2292
Ferrum, 540-365-4469
Floyd, 540-745-9290

Sliding Fee Program

Authorization for Release of Information/ Income Verification from DSS Public Assistance

Applicant's Name (Last, First, Middle Initial) _____

Date of Birth _____ SSN# _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Email _____

County/City of Residence _____

I hereby authorize The Department of Social Services to release information from my file as indicated below to:

TACH @ Laurel Fork
ATTN: Sliding Fee Program
PO Box 9, Laurel Fork VA 24352
276/398-2292
276/398-3331 FAX

TACH @ Ferrum
ATTN: Sliding Fee Program
PO Box 159, Ferrum VA 24088
540/365-4469
276-398-3331 FAX

TACH @ Floyd
ATTN: Sliding Fee Program
PO Box 835, Floyd VA 24091
540/745-9290
276-398-3331 FAX

INFORMATION TO BE RELEASED:

- ☑ Notice of Action
- ☑ Most recent Income Verification
- ☑ SNAP/TANF/WIC/Energy Assistance/etc
- ☑ Other Any other public assistance programs

AUTHORIZATION:

I am applying for the Sliding Fee Program at Tri-Area Community Health and understand TACH needs my income/public assistance verification from the Department of Social Services. Therefore, I authorize the above organizations to communicate freely between one another for the purpose of income/assistance verification. I understand this authorization will be valid for 12 months from the date signed. I understand that I may cancel this authorization by sending a written request for cancellation to TACH, and the cancellation will take effect when TACH receives my written notice.

_____ _____

Signature of Applicant/Patient Date

FOR OFFICE USE ONLY
Faxed ___/___/___

Tri-Area Community Health
www.triareahealth.org

Laurel Fork, 276-398-2292
Ferrum, 540-365-4469
Floyd, 540-745-9290

Sliding Fee Program

Self Employed Statement of Income

(Complete this form only if you are self-employed)

Business Name: _____

Business Owner(s): _____

Business Address: _____

_____

Business Phone: _____

Brief Description of Business: _____

_____

_____

GROSS Earnings (FOR THE BUSINESS OWNER = what you paid yourself, *NOT* the business gross)

Need Past (3) Months. Complete below.

Month	**20**	**Month**	**20**	**Month**	**20**
Week 1	$	Week 1	$	Week 1	$
Week 2	$	Week 2	$	Week 2	$
Week 3	$	Week 3	$	Week 3	$
Week 4	$	Week 4	$	Week 4	$
Week 5	$	Week 5	$	Week 5	$
Monthly Total	**$**	**Monthly Total**	**$**	**Monthly Total**	**$**

_____/_____

Signature of Business Owner Date

Tri-Area Community Health
www.triareahealth.org

Laurel Fork, 276-398-2292
Ferrum, 540-365-4469
Floyd, 540-745-9290

Sliding Fee Program

Statement of Income from Employer

(Have your Employer complete this form)

To Whom It May Concern:

Your employee, _____, is applying for our Sliding Fee Program (to help with medical expenses) . In order to process his/her application, we must have proof of their last/previous month's gross income.

Therefore, please advise us of how much he/she makes per hour, and approximately how many hours he/she works per week.

$_____ per hour x _____ hours per week (approximately)

OR, if the above isn't practical for your type of business, then please complete the following:

GROSS EARNINGS for last/previous month:

Month: _____ 20____ $_____

Name of Employer: _____

Direct Supervisor: _____

Address: _____

Phone: _____

_____ / _____

Employer's signature Date

Tri-Area Community Health
www.triareahealth.org

Laurel Fork, 276-398-2292
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Floyd, 540-745-9290

Sliding Fee Program

ZERO Income - *Self Declaration of Income*

I, _____, certify that I have NO source of income.

Name of last employer _____ Date of last employment _____

Household/Family Size: _____ **HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents**

I am currently:

- ❑ Unemployed – looking for employment. Not receiving unemployment benefits.
- ❑ Seeking Disability. If so, when did you last apply _____? Have you been denied? _____
- ❑ Other _____

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Tri-Area Community Health for sliding fee determination purposes.

Signed: _____ Date: _____

Instructions: If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors.

Statement of Personal Assistance

I, _____, assist _____ (patient) by providing basic living needs listed below:

Food: ❑ Yes ❑ No Relationship to Applicant: _____
Shelter: ❑ Yes ❑ No
Utilities: ❑ Yes ❑ No
Money: ❑ Yes ❑ No Amount $_____

I can be reached to verify this information at:

My Name (Please print): _____
Address: _____
_____
Phone: _____

Signed: _____ Date: _____

Please list any special circumstances on the back of this form