Eastern Shore Rural Health System INCORPORATED
Quality Family Healthcare

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

Atlantic Community Health Center
5219 Lankford Highway
New Church,, VA 23415
757-824-5676
Fax 757-824-5872

Bayview Community Health Center
22214 South Bayside Rd
Post Office Box 970
Cheriton, VA 23316
757-331-1086
Fax 757-331-1129

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

Franktown Community Health Center
9159 Franktown Rd.
Post Office Box 9
Franktown, VA 23354
757-442-4819
Fax 757-442-9505

Onley Community Health Center
20306 Badger Lane
Post Office Box 159
Onley, VA 23418
757-787-7374
Fax 757-787-4513

DENTAL CENTERS

Atlantic Community Health Center
757-824-5676

Franktown Community Health Center
757-442-4819

Pungoteague Elementary School Dental
757-789-7777

Metompkin Elementary School Dental
757-665-1159

Eastern Shore Rural Health System, Inc.
Sliding Fee Application

Proof of income is required to process this application.

Name:_____ **Date of Birth:** _____

Mailing Address:_____ **City/State:** _____

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

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 .

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**

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

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

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

Dependent Family Members:	**Date of Birth:**	**Relationship to Applicant:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____

~~~~~~

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

Interviewer:_____ Date: _____

Please read and sign this form and return it to one of our centers listed to the upper left 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, Bayview, Chincoteague, Franktown, Onley Community Health Centers, Metompkin Elementary 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 check stub (2 are required)
- Most recent tax return
- Monthly Retirement
- Monthly Disability (Can obtain a print out from Disability Office)
- Medicaid or Famis
- 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 _____