BLAND COUNTY MEDICAL CLINIC

Healthy Neighborhood Health Plan

DUE DATE

_____

THIS IS TIME SENSITIVE

_____ _____

NAME DATE

Welcome to the Healthy Neighborhood Health Plan (HNHP). This clinic is federally funded so that we may help patients who are uninsured or underinsured.

To apply for HNHP assistance, you will need to complete the application and return it to our office with proof of annual income for the entire household. These include the following (if they apply):

- ✓ Current year's income taxes (1040, pages 1 & 2)
- ✓ 3 paycheck stubs
- ✓ Copy of food stamp documents
- ✓ Unemployment payments
- ✓ Disability income
- ✓ Retirement
- ✓ Current Social Security Award Statement
- ✓ Child Support
- ✓ Letter stating unemployed with no benefits
- ✓ Tanf
- ✓ Rental Income

LEGAL PAPERS OF CHILD CUSTODY AND SEPARATION OR DIVORCE AND NAME CHANGES ARE ALSO REQUIRED.

YOUR FIRST OFFICE VISIT WILL BE $20.00. THIS INCLUDES LABS, X-RAY, ULTRASOUND, AND EKG. DENTAL AND BEHAVIORAL HEALTH WILL CHARGED ACCORDING TO YOUR INCOME. ALL REQUIRED PAPERWORK MUST BE RETURNED WITHIN 14 DAYS FROM THE DATE OF THE APPLICATION. IF THE REQUIRED PAPERWORK HAS NOT BEEN RETURNED WITH THE 14 DAYS OR IF IT INCOMPLETE, ANY VISITS THEREAFTER WILL BE SELF PAY.

Your information will be updated annually or at any time there is a change in the in the information provided on the application. If you have any questions, please feel free to contact our office for assistance.

Debbie Hull, Patient Coordinator
276-688-2615

Robin Stover, Receptionist
276-688-2615

We look forward to assisting you.

12301 GRAPEFIELD ROAD | BASTIAN, VA 24314
PH: 276-688-4331 | FX: 276-688-4336 | www.blandclinic.com

RCVD:_____

EXPIRES: _____

BLAND COUNTY MEDICAL CLINIC

Healthy Neighborhood Health Plan

GRANTED ☐
DENIED ☐

APPLICATION FOR REDUCED FEE STATUS

APPLICANT'S NAME	SSI#	DATE OF BIRTH
SPOUSE'S NAME	SSI#	DATE OF BIRTH
MAILING ADDRESS		E-MAIL ADDRESS
CITY, STATE, ZIP		PHONE NUMBER
APPLICANT'S EMPLOYER: NAME/ADDRESS/PHONE	SPOUSE'S EMPLOYER: NAME/ADDRESS/PHONE	

ADDITIONAL MEMBERS OF HOUSEHOLD TOTAL NUMBER IN HOUSEHOLD

NAME/RELATION/DATE OF BIRTH	NAME/RELATION/DATE OF BIRTH
NAME/RELATION/DATE OF BIRTH	NAME/RELATION/DATE OF BIRTH
NAME/RELATION/DATE OF BIRTH	NAME/RELATION/DATE OF BIRTH

FAMILY INCOMEDETERMINATION WORKSHEET (please indicate amount and frequency of pay)

WAGES	DISABILITY INCOME	WELFARE PAYMENTS	VETERAN'S BENEFITS
BUSINESS INCOME	UNEMPLOYMENT BENEFITS	AID TO DEPENDENT CHILD	FARM/SEASONAL INCOME
SSI BENEFITS	ALIMONY	FOOD STAMPS	PENSIONS/ANNUITIES
CHILD SUPPORT	OTHER (please specify)	**TOTAL ANNUAL GROSS INCOME**	

OFFICE USE ONLY

REDUCED FEE STATUS CLASSIFICATION: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ NQ

_____ _____

AUTHORIZED SIGNATURE DATE

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BLAND COUNTY MEDICAL CLINIC

Healthy Neighborhood Health Plan

STATEMENT OF UNDERSTANDING

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 purpose of procuring for my own and my family's benefit, the discount of my accounts with Bland County Medical Clinic (BCMC). I understand that BCMC will rely on such information to determine an 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 Commonwealth of Virginia.

I agree to report any change in either my income or my family size to BCMC before or at the time of my next contact or any contact by any family 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. I hereby authored the investigation of all statements contained herein and authorize the release of all of my financial information.

My signature below indicates that all information I have provided is true to the best of my knowledge.

_____

APPLICANT SIGNATURE **DATE**

_____

SPOUSE SIGNATURE **DATE**

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