Greater Prince William Community Health Center

4379 Ridgewood Center Dr, Suite 102, Woodbridge, VA 22192
9705 Liberia Ave, Suite 201, Manassas, VA 20110
17739 Main Street, Suite 130, Dumfries, VA 22026
Phone: 703.680.7950 Fax: 703.680.7953

INCOME VERIFICATION

(This information is required only to determine eligibility for our Sliding Fee Scale Discount Program)

EMPLOYEE / NON-EMPLOYEE SECTION- To be completed by employee / non-employee.

I hereby grant Greater Prince William Community Health Center permission to disclose my income in order to determine eligibility for the Sliding Fee Discount Program (SFDP).

Employee / Non-employee Name: _____ Signature: _____ Date: _____

Income Verification – Submitted when employee / non-employee is unable to provide required pay stubs or is paid in cash.

If an employee is unable to provide required **pay stubs** (i.e., pay stubs are not available and/or employee has started employment and pay stubs have not been yet received) the employee must provide a completed and signed Income Verification form from **each** employer. Once verified, the employee will be considered for eligibility determination for Sliding Fee Discount Program.

If an employee / non-employee is **paid cash** from one or more employer's (individuals, businesses and/or organization), or is **paid cash** from non-employer individual, business and/or organization for casual labor, day labor and/or domestic service (e.g., gardening, landscaping, housekeeping, daycare, babysitting, etc.) and the cash paid is **not** included on the employee / non-employee's tax return, the employee / non-employee must provide a completed and signed Income Verification form from **each** employer and **each** non-employer (i.e., individual, business and/or organization) for services. Once verified, the employee / non-employee will be considered for eligibility determination for Sliding Fee Discount Program.

EMPLOYER / NON-EMPLOYER - This section must be completed by the employer / non-employer.

Name of Individual / Business / Organization | Supervisor / Manager Name | Supervisor / Manager Phone Number

1. Date of Hire: _____/_____/_____
2. Rate $ _____ HOURLY _____ DAILY _____
3. # of Hours Per (a) WEEK _____ OR (b) DAY _____ # OF DAYS PER WEEK _____
4. Tips/Commission Paid $_____ HOURLY _____ DAILY _____ WEEKLY _____ MONTHLY _____
5. How often paid? DAILY _____ WEEKLY _____ BI-WEEKLY _____ MONTHLY _____

I understand Greater Prince William Community Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the employee / non-employee eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately.

Completed By (Printed Name and Title): _____

Signature: _____ Date: _____

Effective Date: **Immediate**
Approved Date: **06/2010, 06/2011, 05/2013**
Revision Date: **04/29/2015, 04/08/2018**