Instructions: If you receive Food Stamps, SSI, or Medicaid, please complete, sign & date this form.

CLINCH RIVER HEALTH SERVICES

SLIDING FEE PROGRAM
17285 Veterans Memorial Hwy
Dungannon, VA 24245
276/467-2201
276/467-2673

Authorization for Release of Income Verification/DSS Public Assistance Programs for Sliding Fee Application

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:**

Clinch River Health Services
ATTN: Sliding Fee Program Coordinator
17285 Veterans Memorial Hwy, Dungannon VA 24245
276/467-2201 • 276/467-2673 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 Clinch River Health Services, and understand that CRHS 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 for the Sliding Fee Program. I understand that 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 CRHS, and that cancellation will take effect when CRHS receives my written notice.

Signature of Applicant_____ Date_____