2024 Income Guidelines

Please identify your family size and household income on the chart below to determine eligibility.

	Tier Two		Tier Three	
Family Size	Greater Than	Up To 175% FPGs	Greater Than	Up To 200% FPGs
1	$15,060	$26,355	$26,355	$30,120
2	$20,440	$35,770	$35,770	$40,880
3	$25,820	$45,185	$45,185	$51,640
4	$31,200	$54,600	$54,600	$62,400
5	$36,580	$64,015	$64,015	$73,160
6	$41,960	$73,430	$73,430	$83,920
7	$47,340	$82,845	$82,845	$94,680
8	$52,720	$92,260	$92,260	$105,440
$5,380 additional for each family member			$9,415 additional for each family member	
Patient Pays 50% of Usual Charge			**Patient Pays 70% of Usual Charge**	

Physician Specialties

Family Medicine
Pediatrics
Internal Medicine
Behavioral Health
Preventative Medicine
Osteopathic Neuromuscular Medicine
Acute Care

Ancillary Services

X-ray
Ultrasound
Bone Density
Lab Services
Social Services
EKG Testing
Immunizations

Robert C. Byrd Clinic

Robert C. Byrd Clinic

On the Campus of the
West Virginia School of
Osteopathic Medicine

PATIENT ASSISTANCE PROGRAM

For More Information
304.645.3220, Ext. 2516
www.rcbclinic.org

The Robert C. Byrd Clinic Patient Assistance Program is available to private pay patients who do not have health insurance coverage. The program allows medically necessary physician services and select on-site ancillary services to be received at a discounted rate dependent on income. Lab, x-ray readings, acupuncture or other ancillary services provided by third parties, or under contract to RCBC, are not covered. Patients are required to use all resources available to them, such as applying for Medicaid coverage. Qualifications for this program require applicants to meet income guidelines based on the current Federal Poverty Level. Patients must reapply annually for this program.

Applicants are required to submit proper state and federal financial documents to verify their income eligibility. The following documents must accompany this application to be considered for the program.

- Current Federal Income Tax Return **AND**

Official monthly statement of benefits received from one of the following:

- Pension
- SNAP/Food Stamps
- Social Security
- Child Support
- Disability
- Unemployment

Applications without supporting documentation will be considered incomplete and will not be processed. Discounted program services are not available without current program enrollment and PAYMENT AT TIME OF SERVICE.

Once a completed application and all necessary financial documents have been received, RCBC will make a determination and notify the patient in writing. Please complete the attached application and return it with the required income verification to:

RCBC Business Office
1464 Jefferson Street N
Lewisburg, WV 24901

Robert C. Byrd Clinic Patient Assistance Application

PATIENT INFORMATION
(One patient per application)

Patient Name: _____
Street Address: _____
City/State/Zip: _____
SSN: _____
Date of Birth: _____
Telephone Number: _____
Spouses Name: _____
Employer: _____
Email: _____

RESPONSIBLE PARTY
(If different from patient information)

Name: _____
Street Address: _____
City/State/Zip: _____
SSN: _____
Date of Birth: _____
Telephone Number: _____
Spouses Name: _____
Employer: _____
Email: _____

Household Size (Number of people residing in your household) _____

Household Income (Please include income of entire household) _____

Patient	One Month	Last Twelve Months	Spouse/ Responsible Party	One Month	Last Twelve Months	Office Use Only
Salary/Income			Salary/Income			
SS/Disability			SS/Disability			
SNAP			SNAP			
Child Support			Child Support			
Other			Other			
TOTAL			TOTAL			

Certification: *I certify, to the best of my knowledge and belief, and under appropriate penalties of law that the above information is accurate, current, and complete. I authorize Robert C. Byrd Clinic or their agents and employees to verify such information as may be required to consider my application for assistance.*
I agree to comply with all conditions of this program, including providing patient payment at time of service. *All information is confidential, as required by law.*

_____
Administrative Signature

_____
Date

APPROVED: ☐ Tier 2 ☐ Tier 3

DENIED: ☐ Incomplete Application ☐ Exceeds Income ☐ Other