



# Application for Sliding Fee Scale - Rural Health Clinics

## PERSONAL INFORMATION

Patient Name: \_\_\_\_\_ Account #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Application: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Monthly Gross Income: \$\_\_\_\_\_ Do you have Medicaid?  Yes  No Have you applied for Medicaid?  Yes  No

Name of Guarantor (If other than the patient) \_\_\_\_\_

## HOUSEHOLD INFORMATION

Number in Family: \_\_\_\_\_ (Please check the box next to members applying for benefits.)

	Name	Relationship	Date of Birth
<input type="checkbox"/>		Self	____/____/____
<input type="checkbox"/>			____/____/____

PLEASE NOTE: If applicant is above age 18 and enrolled in college, proof of full-time student status is required for determination of benefits.

## INCOME CRITERIA

Sources of Income	Income Amount	Weekly	Monthly	Yearly
Salary/Wages Before Deductions	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Assistance	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Security Benefits	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment & Workmen's Compensation	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Benefit	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alimony/Child Support	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Monetary Support	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pension Payments	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance or Annuity Payments	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dividends/Interest	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rental Income	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Net Business Income (self-employed/verified by independent source)	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (strike benefits, training stipends, military family allotment, income from estates and trusts)	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## CERTIFICATION BY APPLICANT

I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal or State governments. Willful misrepresentation of these facts will make me liable for all charges and subject to civil penalties. I agree to permit the health care facility to have access to tax returns. I certify that the above information regarding my family size, income and assets is true and correct. I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_