SLIDING FEE DISCOUNT APPLICATION FORM

(559) 233-0335 • www.FamilyMedicineHealthCenter.com

PATIENT INFORMATION
SECTION 1

Name: _____ Date: _____
(First) (Middle) (Last)

Social Security Number: _____ Date of Birth: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widow

Spouses Name: _____

Patient Name: _____ Applicant Relationship to Patient: _____

HOUSEHOLD INFORMATION
SECTION II

Household Earnings Information:
Please list everyone living in your home (including yourself). Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies. In order to be considered a household member, the person must be listed below. Adults (except for your Spouse) listed below with zero income must provide required documentation.

Name (First and Last)	Age	Source of Income or Employer Name	Monthly Income

Please include income documentation for each ADULT listed above.

Total # of adults (18 years of age and older): _____

Total estimated gross annual income: $ _____

Total # of children (under the age of 18): _____

Total # of household members: _____

Witnessed by FMHC staff: _____

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HOUSEHOLD INFORMATION
SECTION II (continued)

Household Earnings Information:

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Family Medicine Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Family Medicine Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

I consent to the release of any and all of my financial records including but not limited to: sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records that may be deemed necessary for review by any auditor, for participating in any assistance programs including but not limited to sliding fee scale, grant-funded programs and/or pharmacy assistance programs for which I may be eligible.

Date: _____

Name (Print): _____

Signature: _____

Witnessed by FMHC staff: _____