*New Path* **Medical Center**

*...where healing begins*

*Martha Anne Burton, MD & Associates*

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# Sliding Fee Discount Program Application

*New Path Medical Center is a Rural Health Clinic. We are able to offer a discount on some services based on a household's income and size. Sliding fee calculations are determined by using an applicant's total annual income provided by the Federal Income Tax return(s), W-2(s) or 1099(s), most recent pay stubs, Social Security or Pension Income, and Public Assistance award letters. NPMC uses the Federal Poverty Guidelines to determine your eligibility.*

*Your household discount will be assessed once per year. You must reapply for the Sliding Fee discount and provide updated income documentation at this time.*

*If you wish to qualify for the sliding fee, you must show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member. Applicants should provide a copy of either:*

- *Previous year's tax return, W-2's or 1099's*
- *Most recent pay stubs spanning four weeks*
- *Social Security or Pension Income*
- *Public assistance award letters for each adult age 18 and over living in the household*

Name: _____ Date of Birth: _____ Phone: _____

Address: _____

Family Size (number of family members living in your household): _____

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible:

_____

_____

_____

Do you have insurance? YES NO If yes, provide insurance plan name: _____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I understand that providing false information on the SFD application will result in all discounts being revoked and the full balance of the account(s) restores and payable immediately. I further agree to notify New Path Medical Center of any changes in the information within (10) days of such change. I understand that I must re-qualify annually to maintain my eligibility.

I am also aware that this information is reviewed and based upon Federal Poverty, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service.

**Patient Signature: _____**

**Date: _____**

***Return completed application(s) and income documentation to:***
***P.O. Box 1780, Columbia, KY, 42728***

***INTERNAL USE ONLY***

*Annual Gross Income _____*

*Patient is eligible for SFD category _____*

- ☐ *Proof of Income Verified*
- ☐ *Patient refused to complete*
- ☐ *Patient does not qualify for SFD*

_____

*Verified by* *Date*