Family Medicine

Discounted/Sliding Fee Application

It is the policy of Family Medicine to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-rays, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

NUMBER OF RELATED PERSONS (IMMEDIATE FAMILY) LIVING IN YOUR HOUSEHOLD : _____

HOUSEHOLD INCOME (complete one column)

HOUSEHOLD MEMBER	Annual	Monthly	Bi-weekly
Self			
Spouse			
Dependent Children Under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

NAME (print)_____ DATE_____

SIGNATURE_____

Office Use Only:

Patient name _____ Discount_____

Date of Service_____ Approved by_____

Family Medicine Assistance Plan Application

Name of head of Household			Place of Employment	
Street	City	State	Zip	Phone
Health Insurance Plan			Social Security Number	

Please list spouse and dependents under age 18

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
self		dependent	
spouse		dependent	
dependent		dependent	
dependent		dependent	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
TOTAL INCOME				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (print)_____ Date_____

Signature_____

Office use only:

Patient name_____Discount_____

Date of service_____Approved by_____

Verification Checklist (attach copies)	yes	no
Identification/address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax teturn, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection		