YourTown Health

Sliding Fee Program Application

Name:____ Date: _______________________

Mailing Address: ____
PO Box or Street Town State Zip Code

Home Phone No. ________________ Cell Phone No. _______________ Email: _______________

Have you been enrolled in the Sliding Fee Program before? Yes No

HOUSEHOLD INFORMATION

Please list ALL MEMBERS of your household (include yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes. **If child is over 18, indicate if student.**

Name	Birth Date	Relationship to Applicant
		Self

_____ I have no health insurance coverage
_____ I have health insurance coverage through ____.
If you have insurance, we will bill your insurance carrier and apply the discount to any balance due for co-pays and deductibles.

Please fill out the income information section below for ALL members of your family. If you have no source of income, please go to zero income section on next page.

INCOME INFORMATION

Sources of Income	Name of Source	Gross Annual Income
Wages		
Self-employed (net receipts after deductions)**		
Social Security Benefits (SSI, Survivor's, Disability)		
Public Assistance (TANF, General Assistance, etc.)		
Child Support/Alimony		
Unemployment Benefits, Workers' Compensation		
Stocks, Dividends, Rental Property		
Interest Income		
Other (Pensions, Veteran's Benefits, Union, etc.)		

****If you are self-employed, you must provide your most recent Federal Income Tax Return (1040) with accompanying Section C.**

YOU MUST INCLUDE PROOF OF INCOME SUCH AS PAYCHECK STUBS, COPIES OF UNEMPLOYMENT CHECKS AND/OR SOCIAL SECURITY CHECKS.

Without proof of income our application will not be processed and your enrollment into the program will be delayed. If you have difficulty getting proof of income, speak to the Medical Center's Customer Service Representative who can assist in recommending sources of proof. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

ZERO INCOME

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: ___________________________________ Date of last employment: _______________
Please explain how your basic needs have been met:
Food: ___________________________________ Utilities: ____
Shelter: _________________________________ Non-food items (clothing, etc.): ________________________

I, ________________________________, certify that I have had no source of income since________________.

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.

- I agree to be responsible for my Community Medical Center bills.
- I also agree to tell the Medical Center if I become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the above information on this application is correct and all sources of income required have been reported. I further understand that I will need to update my application every six months even if no changes occur.

Signature: ______________________________________ **Date:** _______________________

PHC, Inc. Use Only:

Total No. of Family Members: _____________ **Payment Eligibility:** ___________________
Combined Family Income: ________________ **Date of Application:** ___________________
Verification Source: ______________________ **Renewal Date:** ________________________

Application Completed By: ___________________________________