Sliding Fee Eligibility Form

To provide you with the proper discount on our medical expenses it is necessary for us to ask you some questions regarding your finances. This information is confidential and will only be kept for our records. Your annual income will be used to calculate the level of your payment on this sliding scale.

Last Name:	Middle:	First Name:	Date of Birth:

Social Security Number:	Phone:

Address:	City/State:	Zip Code:

Household Size:	Do you own or rent your home?	Marital Status:
	☐ Own ☐ Rent ☐ Live with Someone	☐ Single ☐ Married ☐ Separated ☐ Widow ☐ Divorced

Amount of Household Income?				
You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment?			
You	Your Spouse	Your Children	Other Person

Do you receive any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Rental Income					
Interest Income					
Child Support, Alimony					
Other _____					

List below name, date of birth, and social security number (if available) of all family members.		
First & Last Name	**Date of Birth:**	**Social Security Number**

Do you have any type of insurance that will cover all or a portion of your medical expenses?

☐ No

☐ Yes, list below

_____

_____

_____

I declare the above information is true and have given FirstMed Health & Wellness Center permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Patient Signature:	Date:

Clinic Use Only			
☐ Denied ☐ Approval	% of FPL:	OV:	Amerigroup Eligibility: ☐ Approved ☐ Denied
Staff Signature:		Date:	