



# APPLICATION FOR RURAL HEALTH CLINIC PAYMENT SLIDING FEE PROGRAM

**DO NOT SEND ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.**

## SECTION I – Personal Information

1. PATIENT NAME		2. Account _____
_____ (Last)	_____ (First) (MI)	
3. DATE OF APPLICATION	4. Date of Birth:	
_____/_____/_____ Month Day Year	_____/_____/_____ / /	
6. STREET ADDRESS OF PATIENT		7. TELEPHONE NUMBER
		(_____) _____ - _____
8. CITY, STATE, & ZIP CODE		9. Monthly GROSS Income
		\$ _____
10. Do you have Medicaid? _____ Have you applied for Medicaid? _____		
11. NAME OF GUARANTOR (If other than patient)		

## SECTION II – Household Information

12. Number in Family: \_\_\_\_ - List Names, Date of Birth and Relationship. (Please indicate members applying for benefits)

- \_\_\_\_\_ / SELF \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**\*PLEASE NOTE: if applicant is above age 18 and enrolled in college, proof of Full-Time Student Status is required for determination of benefits.**

# APPLICATION FOR RURAL HEALTH CLINIC PAYMENT SLIDING FEE PROGRAM

## SECTION II Income Criteria

		Week	Mo	Yr
<b>14. SOURCES OF INCOME</b>				
<b>A. Salary/Wages Before Deductions</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Public Assistance</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Social Security Benefits</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Unemployment &amp; Workmen's Compensation</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Veteran's Benefit F. Alimony/Child Support</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Other Monetary Support</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Pension Payments</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>H. Insurance or Annuity Payments</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Dividends/Interest</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Rental Income</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K. Net Business Income (self-employed/verified by independent source)</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L. Other (strike benefits, training stipends, military family Allotment, income from estates and trusts.)</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>N. TOTAL</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SECTION III – Certification By Applicant

**I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal or State governments. Willful misrepresentation of these facts will make me liable for all charges and subject to civil penalties.**

**I agree to permit the health care facility to have access to tax returns.**

**I certify that the above information regarding my family size, income, and assets is true and correct.**

**I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.**

**16. SIGNATURE OF PATIENT OR GUARANTOR**

**17. DATE**