Salyersville Medical Center

601 East Maple Street Salyersville, Kentucky 41465 606-349-5300

MEDICAL OFFICES SLIDING FEE PROGRAM APPLICATION

Patient's Name _____ **Date of Birth** _____

Address _____

Telephone Home _____ **Cell** _____

Employer _____ **Telephone** _____

Address _____

Number of persons in your household (include yourself) _____

Monthly Income _____

Monthly Expenses _____

PLEASE CHECK APPROPRIATE BOXES:

☐ **I hereby certify that the above information is true and correct.**

☐ **I hereby certify that I do not have any Insurance, Medicare or Medicaid, Workers Compensation or any other third party payer to assist me with my medical expenses.**

☐ **I agree to notify this office immediately should I become eligible for any form of insurance or third party payer.**

☐ **I agree to notify this office immediately of any change in my income or my spouse's income.**

☐ **I understand that this discount is subject for review at any time and will be reviewed on a regular basis.**

☐ **I hereby certify that the amount of income listed above is the TOTAL amount of income received by me and my family from all jobs or sources.**

Eligibility is based on Gross Household Income. You must bring one of the following to the clinic to determine if you are eligible. Please check the verification(s) you are submitting:

☐ **Current year's tax form (1040 form)**

☐ **2 current pay stubs**

☐ **1 unemployment stub**

☐ **Letter from employer on letterhead that states your salary or wages**

☐ **If none of the above are available, you must provide a letter of reference from any 501(c)(3) (non-profit) organization on their letterhead (for example, your church).**

Signature _____ **Date** _____

Office Manager _____ **Date** _____

Approved: _____ **YES** _____ **NO**

Notes _____

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