SANDHILLS MEDICAL FOUNDATION, Inc.

Sliding Fee Eligibility Form

Today's Date: _______

DEMOGRAPHIC INFORMATION:

Name:	Social Security #
Address:	Date of Birth:
City, State, Zip	
Primary Phone Number:	Other Phone:

HOUSEHOLD INFORMATION MUST BE COMPLETED FOR ALL APPLICANTS

Number of people living in your household: _____

List all members of household:

Name:	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB

AMOUNT OF FAMILY INCOME: Please specify if Weekly, Bi-weekly, Monthly or Yearly

You	Your Spouse	Your Children	Others

HOUSEHOLD INCOME:

Employer Name or/ Self Employed:

OTHER SOURCES OF INCOME:

☐Social Security ☐Child Support ☐Public Assistance ☐Retirement Pension
☐Food Stamps $_____ ☐Rental Income ☐Interest Income ☐Other (Specify)

GROSS WAGES PAY PERIOD: ******YOU MUST PROVIDE <u>TWO</u> MOST RECENT PAY-STUBS OR W-2 or TAX RETURN FROM <u>LASTEST YEAR ENDED</u>******

Weekly Income:	X 52	Total:
Bi-Weekly Income:	X 26	Total:
Monthly Income:	X 12	Total:
Semi-Monthly:	X 24	Total:
Yearly Income:	X 1	Total:

I declare the above information is true and I have given Sandhills Medical Foundation, Inc. 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 during my next visit to the clinic. I also understand I must recertify every twelve months.

Signature:	Date:	Clinic purpose only Income code/clerk initials: