Broad Top Area Medical Center, Inc.

SLIDING FEE SCALE APPLICATION

Applicant's Information

First Name: Middle: Last: Other Names:

_____

Home Address: City: State: Zip:

_____

Mailing Address: City: State: Zip:

_____

Home Phone #: Cell Phone #: Work Phone #:

_____

Date of Birth: Social Security #: Marital Status: (Circle One)

_____ Single Married Domestic Partnership

Divorced Separated Widowed/Widower

_____

Note: To comply with federal regulations, in order to give you a discount on our services, it is necessary to ask some personal questions. Your answers will be kept on file and in strict confidence. We must verify your gross income every Sliding Fee reporting year, 03/01 to 02/28 or 02/29 in a leap year.

Proof of income can be verified by presenting us with your income tax return from previous year, last month's paycheck stubs, copies of your social security checks, or other checks you receive will be sufficient proof.

Your household size and household income will be used to calculate your discount. For the purposes of income determination, a family is defined as an individual **or** a group of two or more persons related by birth, marriage, domestic partnership, adoption, or guardianship that live in your household.

Household Size

NAME:	DATE of BIRTH:	SOCIAL SECURITY NUMBER:
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____

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Wage Income that Contributes Household:

NAME	EMPLOYER	FREQUENCY (Circle One)	AMOUNT
You:		Weekly Bi-Weekly Monthly Yearly	$
Spouse/Partner:		Weekly Bi-Weekly Monthly Yearly	$
Children:		Weekly Bi-Weekly Monthly Yearly	$
Other:		Weekly Bi-Weekly Monthly Yearly	$
Other:		Weekly Bi-Weekly Monthly Yearly	$
		Total Wage Income:	$

Other Income that Contributes to the Household:

	You	Spouse/Partner	Children	Other	Subtotal
Unemployment Benefits					$
Retirement or Pension Benefits					$
Social Security Benefits					$
Cash Assistance or Food Stamps					$
Child Support or Alimony					$
Royalty or Annuity Payment					$
Other Income					$
				Total of Other Income:	$
				Total of Wage Income:	$
				ANNUAL HOUSEHOLD INCOME:	**$**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the Sliding Fee Discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform the Broad Top Area Medical Center, if there is a significant change in my income. If qualification for the Sliding Fee Discount program is approved under this application, I will comply with all rules and regulations of Broad Top Area Medical Center. I hereby acknowledge that have read the foregoing disclosure and understand it.

_____ _____

Print Name of Applicant or Parent/Guardian Date

_____

Signature of Applicant or Parent Guardian