

Broad Top Area Medical Center, Inc.
SLIDING FEE SCALE APPLICATION

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					\$
Social Security Benefits					\$
Retirement or Pension Benefits					\$
Alimony or Child Support					\$
Royalty or Annuity Payment					\$
Other Income					\$
Cash, Heat, or Food Assistance	YES	NO	(Not counted as taxable income for Sliding Fee Scale)		
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, Inc. 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