Broad Top Area Medical Center, Inc.

SLIDING FEE SCALE DISCOUNT PROGRAM – APPLICATION FORM

Applicant's Information:

First Name: Middle: Last:

_____

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, and to determine eligibility for discounted services, it is necessary to ask some personal questions. Your answers will be kept on file in strict confidence. To qualify for the Sliding Fee Scale Discount Program (SFS) we must verify your gross income every benefit year, from March 1 to the last day of February.

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 unemployment or social security determination, or bank statement of deposit will be sufficient proof.

Your household size and household income will be used to calculate your eligibility for 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:

FAMILY MEMBER'S NAMES	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					$
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 SFS Program and may subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform BTAMC if there is a significant change in my income. If my application is approved and qualified for the SFS Program, I will comply with all BTAMC rules and regulations. 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:

PLEASE INDICATE SERVICE TYPE:

MEDICAL _____

DENTAL _____

BOTH _____

(revised) 8.8.2022/RAH