

**EDINBURGH / TRAFALGAR FAMILY HEALTH CENTERS
Sliding Fee Scale Application**

Name		Social Security Number		
Street	City	State	Zip	Telephone
Do you have Health Insurance? Y or N		If Yes, what is the name of your Insurance Company?		

Please list spouse and dependents under age 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Are Children under 18 covered by Medicaid? ___ Yes ___ No

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment				
Rent, interest, dividend, and other investment income				
Other income				
Total Income				

Verification Checklist (attach copies)		Yes	No
1. Identification: Driver's license, birth certificate, employment ID, social security card or other			
2. Income: Prior year tax return or W-2's, three most recent pay stubs, or other			
3. If Item 2 is checked No, does the patient / guarantor self-attest that the above information is true?			

I certify that the information shown above is accurate and true. I understand that if I have provided false information, my account will default to the full amount due for services rendered. I also understand that this application is good for six (6) months, after which time, I will be asked to update my information.

Patient / Guarantor Signature

Date

Office Use Only

Discount Approved: Min 75 25 50 0 Effective date: _____

Approved by: _____ Expiration date: _____