ROANE COUNTY FAMILY HEALTH CARE
SLIDING FEE APPLICATION

Patient Name:_____

Address: _____ **Phone #**_____

_____

LIST ALL PERSONS LIVING AT THE ABOVE ADDRESS **(include self):**

NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #	TYPE OF INSURANCE	CURRENTLY FHC PATIENT?
	Head of Household				

LIST ALL INCOME FOR YOUR ENTIRE HOUSEHOLD **(include self):**

TYPE OF INCOME	AMOUNT OF PAYMENT (WAGES BEFORE TAXES)	HOW OFTEN ARE YOU PAID? (CIRCLE IF WAGES)*
WAGES	**$**	**Monthly/Weekly/Every 2weeks/Twice a month/ Other (please explain) -**
SOCIAL SECURITY BENEFITS	**$**	
DISABILITY BENEFITS	**$**	
VA BENEFITS	**$**	
UNEMPLOYMENT BENEFITS	**$**	
ALIMONY/CHILD SUPPORT	**$**	
FOOD STAMPS	**$**	
OTHER (PLEASE EXPLAIN)	**$**	

I certify that the statements in this form are true and correct to the best of my knowledge. I give Family Health Care personnel permission to verify the information contained therein. I understand that it is my responsibility to advise Family Health Care of any change in my income, insurance coverage, or household status. IF MY HOUSEHOLD INCOME IS INCREASED AND I DO NOT NOTIFY FAMILY HEALTH CARE, I WILL BE RESPONSIBLE FOR ANY ADDITIONAL CHARGES FROM THE DATE MY INCOME INCREASED.

SIGNATURE _____ **DATE** _____

FHC WITNESS _____ **DATE** _____

FHC OFFICE USE ONLY:

ANNUAL INCOME: _____ **VERIFIED BY/DATE** _____

APPROVED (COPAY PER VISIT): $10 $15/15% $20/20% $40/40% $60/60% $80/80% NOT QUALIFIED

EFFECTIVE DATE: _____ **EXPIRATION DATE**_____