

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	\$20	\$40	\$60	NOT QUALIFIED
EFFECTIVE DATE:	_____	EXPIRATION DATE	_____		