Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on your medical expenses. This information will be kept on file in our Billing Department in strict confidence. You must verify your income yearly from the day you start using the clinic. Proof of income includes tax filing statement, check stubs, or award letters. Your annual income will be used to calculate your payment for clinic services.

Name:	Address:
Date of Birth:	City/State/Zip:
Social Security Number:	Phone Number:
Employer:	Employer Number:

Today's Date: ____________________ Number of people living in your home? _____

What is your marital status? Circle One: Single/Married/Divorced/Separated/Widow(er)

Do you rent or own your home? Circle One: Rent Own Live with someone

Amount of Household Income

Yourself	Spouse	Children	Other Person	Total Income

Do you have any type of insurance that will cover all or a portion of your medical expenses? Yes or No

If yes, please list insurance name and ID # - ___________________________________

Please give Names and Date of Births for anyone living in the home:

Name	Date of Birth

I declare the above information is true and have given Triangle Area Network permission to verify any and all information given in this application. I also understand that if my income changes I must notify the Front Desk or Billing Department. I understand all my information will be kept in strict confidence.

Signature:	Date:	Income Category – If Eligible (Office Only):

________ I understand my rights under the Sliding Fee Program