Sliding Fee Discount Application

HARRIS FAMILY CARE FRANKLIN | HARRIS MEDICAL ASSOCIATES | HARRIS PEDIATRIC CARE | SWAIN FAMILY CARE | HARRIS WOMEN'S CARE

It is the policy of Western Carolina Physician Practice Management, LLC., NHSC approved sites to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

PATIENT NAME:			DATE OF BIRTH:
STREET ADDRESS:	CITY:	STATE:	ZIP:
SOCIAL SECURITY NO:	TELEPHONE:		
NAME OF HEAD OF HOUSEHOLD (HOH):	HOH PLACE OF EMPLOYMENT:		

Please list Head of household, Spouse and Dependents under the age of 18

SELF:	DATE OF BIRTH:
SPOUSE:	DATE OF BIRTH:
DEPENDENT 1:	DATE OF BIRTH:
DEPENDENT 2:	DATE OF BIRTH:
DEPENDENT 3:	DATE OF BIRTH:
DEPENDENT 4:	DATE OF BIRTH:
DEPENDENT 5:	DATE OF BIRTH:
DEPENDENT 6:	DATE OF BIRTH:
DEPENDENT 7:	DATE OF BIRTH:

Annual Household Income:

INCOME SOURCE:	GROSS WAGES, SALARIES, TIPS, ETC.	INCOME FROM BUSINESS, SELF-EMPLOYMENT, AND DEPENDENTS	UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, PUBLIC ASSISTANCE, VETERANS' PAYMENTS, SURVIBOR BENEFITS, PENSION OR RETIREMENT INCOME	INTEREST, DIVIDENDS, RENTS, ROYALTIES, INCOME FROM ESTATES, TRUSTS, EDUCATIONAL ASSISTANCE, ALIMONY, CHILD SUPPORT, ASSISTANCE FROM OUTSIDE THE HOUSEHOLD, AND OTHER MISCELLANEOUS SOURCES.
SELF:				
SPOUSE:				
ALL DEPENDENTS:				
TOTAL:				

REQUIRED INFORMATION FOR VERIFICATION:

1. PRIOR YR W-2, TWO MOST RECENT PAY STUBS, LETTER FROM EMPLOYER, OR FORM 4506-T (IF W-2 NOT FILED)
2. TWO FORMS OF IDENTIFICATION/ADDRESS

   (STATE ISSUED PHOTO ID, UTILITY/TELEPHONE BILL)

RETURN THIS APPLICATION TO:

Any eligible practice listed at top of form.

I certify that the family size and income information shown above is correct.

NAME (PRINT):

SIGNATURE:

DATE:

Office Use Only

VERIFICATION CHECKLIST	**YES**	**NO**
Prior yr W-2 or Tax Return, Two most recent pay stubs, Letter from Employer, or Form 4506-T.		
Identification/Address - forms used.		
If Self Employed, Business Income & Expenses for most recent 3 months.		
Insurance: Insurance Cards		

PATIENT NAME:	NOTES:
APPROVED DISCOUNT %:	
APPLICATION VERIFIED BY:	
CFO APPROVAL:	