SCOTLAND PHYSICIANS NETWORK

An affiliate of Scotland Health Care System

Sliding Fee Discount Application

It is the policy of Scotland Physicians Network's primary care clinics to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. "Family" is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related family members) are considered as members of one family.

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.

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT
STREET	CITY	STATE
ZIPCODE	PHONE NUMBER	Please indicate whether you reside in Marlboro County

**County location and address are not used for sliding fee determination. Marlboro County residents may also be eligible for Marlboro Trust assistance.

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers'				

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compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor 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				
Total income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

- I verify that all the above information I have supplied is true and complete. I give my permission for the information relating to this application to be reviewed by the Practice staff and used as appropriate for accounting and authorization purposes. All information received will remain confidential, and not released to any party without the expressed written permission by the above individual.

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

Name (Print)	**Date**
Signature	

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		