

ADAMS COUNTY HEALTH CENTER

SLIDING FEE PROGRAM APPLICATION

Date of Request: ____/____/____ Return Completed Application in Five Working Days or Before.

Patient's Name: (print) _____

Mailing Address: _____

Telephone Number (or message number): _____

Number of Persons Residing in Household: _____

Name of all residing in household	Date of Birth	Relationship	SSN	Employer	Applying for Discount	
					Yes	No
		Self				
		Spouse/Partner				
		Child				
		Child				
		Dependent				

If more room is needed for Children or Dependents please add them to the back of the form.

Income/Note: YOU MUST PROVIDE INCOME VERIFICATION.

Annual Household Income				
Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, disability, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments, AFDC				
Unemployment, workers compensation, strike benefits, etc.				
Rent income, interest, dividends, and other income				
Total income for the last twelve (12) months				

Do you have any insurance coverage for the Medical charge(s): Yes _____ No _____

If yes: Medicaid ____ Medicare ____ Private Insurance (Name) _____

Verification Checklist (attach copies)	Yes	No
Identification/Address: Drivers license, birth certificate, SS card, employment ID, or other		
Income: Tax returns, pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection		

I certify that the information shown above is correct and understand verification is required for approval.

Name (Print)

Signature/Date

For Office Use Only	
Date Application Received: _____	Received by: _____
Discount % Pay Class: Primary Health: _____, Mental Health: _____, Dental Health: _____, Pharmacy: _____	
Patient Name _____	
Patient Name _____	
Patient Name _____	
Patient Name _____	
Patient Name _____	
Patient Name _____	
Valid _____	To _____ Approved by: _____