Gaston Family Health Services, Inc.

SLIDING SCALE FEE APPLICATION

Patient Name (First, Middle, Last): _____ Date of Birth: _____

Mailing Address: _____ Phone: _____

City, State, Zip: _____ SS#: _____

Total in Family Unit: _____ Number of Adults _____ Number of Children _____

Do you have Health Insurance or Medicaid? YES ____ NO ____ If yes, What type? _____

SOURCES OF INCOME FOR APPLICANT AND PERSONS IN THE FAMILY (Dependents)

***Applicant must provide documentation with the application. A list of appropriate documents is listed below. Provide the documents that are applicable to you and your family.

- **Applicant's Salary** - Provide at least one of the following as applicable to you:
  - Two most recent pay stubs
  - Letter on letterhead from employer that states current hourly rate and normal number of hours in work week
  - If self employed, provide your most recent tax returns including 1099 Schedule C
- **Other Family Member's Salary**: Provide at least one of the items required for the applicant's salary.
- If unemployed (either applicant or other family members), please provide:
  - Wage history (from Employment Security Commission) AND
  - Unemployment Wage Summary (from E.S.C.)
- Current statement for disability, social security, and/or pension showing monthly earnings
- Alimony and/or child support – Indicate amount paid or provide statement of monthly alimony and/or child support income.
- Worker's compensation benefits
- VA/pension income
- Public Assistance
- Food Stamp Verification
- **No source of income** - Provide us with a letter that supports your current financial status. This letter may ONLY come from a minister/priest/rabbi, director of a homeless shelter, landlord, or social/case worker. Complete and provide the 'Verification of income received from relatives/friends' form (Notarized).

Total in Family Unit _____ Number of Adults _____ Number of Children _____ Under 18 _____
***The total number of family members is used for discount determination.

Family unit members to be included for sliding fee scale determination:

Name	DOB	Relationship	Income $	Frequency of Payment	Source
		Applicant			

Total Household Gross Income: $_____

- All of the information provided on this application is true and correct and the applicant has not omitted any material matters in providing the information.
- At anytime there is a change in the total family income or health care coverage, Gaston Family Health Services will be notified and such change will be supported by the submission of appropriate documentation.
- Approval of this application is limited to a maximum of (6) months from the date of approval.
- The applicant is at least 18 years old, has been declared by a court to be emancipated, or is emancipated by marriage or other legal definition.
- If the applicant participates in pharmaceutical assistance programs offered by Gaston Family Health Services' pharmacy department, permission is given for the pharmaceutical companies or its designees to review records for audit purposes.

I agree that failure to provide proof of income will remove me and my family from the Gaston Family Health Services, Inc. sliding fee scale discount program. I understand that my fees are based on the financial information which I have provided and agree that the information provided is true and includes all household income. I agree to notify Gaston Family Health Services, Inc. of any and all changes to my insurance status and/or household income.

Signature of Applicant or Parent/Guardian _____ Date Signed _____

Witness Signature _____ Date Signed _____