Application for Reduced Fees

It is necessary for us to ask personal questions in order to give you a discount on your medical/dental expenses. This information will be kept on file in our clinic in strict confidence. You must verify your income at least once every year. Proof of Household Income may include:

- Your yearly income tax return and/or a copy of your W-2 form
- 1 current pay check stub
- A copy of your social security checks
- Checks or documents or Other income you may receive

Your annual household income will be used to calculate the level of your discount.

Responsible Party Name:_____Acct#_____
Address:_____City:_____State:____Zip_____
DOB:_____SSN#_____-_____-_____Telephone:_____
***TOTAL number living in your household, include yourself:_____**
Marital Status(Circle One): Single Married Separated Divorced Widow(er)
***Is anyone in your household employed? Yes or No**
List names of other members of household:

_____

_____

_____

I declare the above information is true and I have given MDHS permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit.

If you do NOT wish to apply for our Sliding Fee Scale:

Mid-Delta is a Federally Qualified Health Center. We are required to obtain household income information for reporting purposes. Please indicate your family's annual income. This helps us report income data even if you are not applying for the sliding fee scale.

How many people are in your household? _____

____ $0 - $10,000	____ $10,000 - $20,000	____ $20,000 - $30,000	____ $30,000 - $40,000
____ $40,000 - $50,000	____ $50,000 - $60,000	____ $60,000 - $70,000	____ $70,000 - $80,000
____ $80,000 - $90,000	____ $90,000 - $100,000	____$100,000 +	____ Wish not to disclose

□ **I refuse to provide my proof of income to apply for the reduced fees. In doing so, I agree that I will be responsible for the bill in full.** **(ONLY CHECK BOX IF YOU ARE NOT PROVIDING)**

_____ _____ _____

Responsible Party Signature Date Interviewer Signature

OFFICE USE ONLY

Weekly Gross Pay $_____x4.334=
Bi-Weekly Gross Pay $_____x2.167=
Twice Monthly Gross Pay $_____x2.00=
Monthly Gross Pay $_____x 12=
Totals x 12 Months
Total Annual Income: $_____
Expiration Date: _____(1 year from today)