GAGON FAMILY MEDICINE + URGENT CARE

SLIDING FEE DISCOUNT APPLICATION

It is the policy of Gagon Family Medicine to make available discount services to those in need regardless of their ability to pay. Discounts are based only on family size and annual income. Please complete the following information and return to the receptionist. The discount will apply to visits received at Gagon Family Medicine but **not** those services purchased from outside, including laboratory testing, drugs and x-ray interpretation by a consulting radiologist and other similar services. You **must** complete this form every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSE:				PLACE OF EMPLOYMENT:
STREET:	CITY:	STATE:	ZIP:	PHONE:

Please list all household members and dependents under the age of 18 below.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

Please provide source of income information below.

SOURCE	SELF		OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's 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: Please provide copies of one (1) of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals must submit detail of the three most recent months of income and expenses for the business. Self-declaration of income may be used in certain circumstances.

I certify the family size and income information shown above is correct. I understand that providing false information will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

Name (Print): _____

Signature: _____ **Date:** _____

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		