SLIDING FEE DISCOUNT APPLICATION

It is the policy of Gagon Family Medicine to provide essential services regardless of the patient's ability to pay. Gagon Family Medicine offers discounts based on family size and annual income.

Please complete the following information and return to the receptionist to determine if you or members of your family are eligible for a discount.

The discount will apply to essential services 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 such services. You **must** complete this form every 12 months or if your financial situation changes.

NAME				
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**

Please list all household members, including those under age 18.

NAME	**DATE OF BIRTH**	**NAME**	**DATE OF BIRTH**
SELF		OTHER	
OTHER		OTHER	
OTHER		OTHER	

Please provide source of income information below.

SOURCE	**SELF**		**OTHER**	**TOTAL**
Gross wages, salaries, tips, etc.				
Income from business and self-employment.				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income				
Interest, dividends, royalties, income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources				
TOTAL INCOME				

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

Name (Print): _____

Signature: _____ **Date:** _____

NOTE: Please provide driver's license, utility bill, employment identification, or other documentation to verify identity and address. Please also provide copies of one (1) of the following: prior tax return, three most recent pay stubs, or other such as letter from employer. 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

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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		