Lackey Memorial Hospital
APPLICATION FOR SLIDING FEE

For your assistance, we have a sliding fee scale. In order for us to determine if you qualify for the sliding fee scale, please provide us with the following information.

How many people are supported by this income? _____
Use the number of persons in your family who live in the same household who share income, food and/ or rent. That number includes you, your spouse, and /or any dependents.

Mailing address:_____ Phone Number_____
_____
_____

Please list the people you have included:

NAME	RELATIONSHIP	SOURCE OF INCOME	EMPLOYER

Is anyone in your household receiving TANF assistance?_____
Is anyone in your household currently enrolled with Medicaid?_____

Please list MONTHLY gross income per item for your household:

Employment:_____ **Disability :_____**
Unemployment:_____ **Pension Funds:_____**
Self-Employment:_____ **Savings Trusts:_____**
Social Security:_____ **VA Benefits:_____**
Child Support:_____ **Spouse Support:_____**
Public Assistance:_____ **Food Stamps:_____**
Other:_____

Total Monthly Income $_____(You must bring proof of income)

To the best of my knowledge, the information given is true and correct. I give Lackey Memorial Hospital and affiliated clinics permission to verify information about my financial status.
I understand this information must be provided within 30 days of the date of the visit to qualify for the sliding fee discount. If this information is not received, then I understand that I will be responsible for the fill fee for the visit.

_____ _____ _____
Patient Name Patient Signature Date

For office use only:

Annual Income:_____#Household_____Sliding fee Level_____Int____