North Mississippi Primary Health Care

Sliding Fee Discount Program Application

Patient Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Do you currently quality for food stamps? Yes or No (circle one)

Family Size*:*

Family size is defined as a group of two (2) people or more (one of whom is head of household) related by birth, marriage, or adoption and residing together. The household size will be limited to immediate family - spouse, partner, children, and dependents.

Circle One: 1 2 3 4 5 6 7 8 Other: _____

Household Member(s) (First & Last Name)	Relationship	Social Security Number	Date of Birth	Income Source	Gross Income	How often received

Applicant will provide a copy of applicable documents

- Most recent Federal Tax Return (1040, 1040 EZ, 1040A)
- Most recent pay stubs from 1 month of earnings
- Social Security Benefit Letter
- Letters of Income Affidavit
- Veterans Benefit Letter
- Retirement Benefits Letter
- Verification of Unemployment Benefits
- TANF/SNAP Application or Benefit Letter
- Bank Statements (SS deposits)
- Explanation of Support Affidavit

For households who report no income, an Explanation of Support ***must*** be completed

Do you currently have health insurance? Yes or No (circle one) If Yes circle which one(s): Medicaid Medicare Commercial Other
(Request copy of card)

PLEASE IDICATE YOUR CURRENT LIVING ARRANGEMENTS

- ☐ Own/Rent
- ☐ Homeless Shelter Name of Shelter_____
- ☐ Transitional (living in a halfway house) Name of Transitional Home _____
- ☐ Doubling up (Live with relative or friend)
- ☐ Street

I certify that the information I have provided regarding my present financial status, family composition, and living arrangements is true and accurate. I agree to inform North Mississippi Primary Health Center (NMPHC) if there is any change in my household income or family size. I understand that it is my responsibility to provide income verification within 30 days of original application.

Patient Signature: _____

Date: _____

FOR INTERNAL USE ONLY

Total Annual Gross Income $_____
Family Size: _____

- Proof of income received/verified
  Slide Class: A B C D E
- Patient does not qualify for Sliding Fee Discount Program

Employee Signature: _____

Date: _____

Sign below only if you do **NOT** wish to apply for discounted services

I have been offered to apply for NMPHC's Sliding Fee Discount Program and **I do not wish to apply at this time**. I understand that **I will receive no discount** on services.

Patient Signature_____ Date _____