Date_____ Sliding Fee Expiration Date_____

Sliding Fee Code (circle one) A B C D E SELFPAY

NORTH CENTRAL FAMILY MEDICINE
APPLICATION FOR SLIDING FEE

HOUSEHOLD MEMBERS					
Name	Sex	Date of Birth	Relationship	Social Security Number	Identification Card
TOTAL IN HOUSEHOULD					

INCOME OF HOUSEHOLD			
	SELF (A)	SPOUSE (B)	OTHER(S) (C)
1. IRS TAX FORM			
2. GROSS WAGES MONTHLY			
3. PUBLIC ASSISTANCE AFDC			
4. SOCIAL SECURITY BENEFITS			
5. UNEMPLOYMENT			
6. PENSION			
7. WORKERS COMPENSATION			
8. SSI / DISABILITY INSURANCE			
9. VETERANS BENEFITS			
10. RAILROAD RETIREMENT			
11. CHILD SUPPORT			
12. ALIMONY			
13. OTHER (SPECIFY)			
TOTAL HOUSEHOLD INCOME (Add Column A + B + C)			

I, THE UNDERSIGNED, CERTIFY THAT THE INCOME AND OTHER REGISTRATION INFORMATION GIVEN BY ME TO NCFMC FOR THE PURPOSE OF RECEIVING MEDICAL CARE FROM THE AUTHORIZED PROFESSIONAL STAFF OF NCFMC IS CORRECT AND ACCURATE.

SIGNED_____ NCFMC STAFF_____

(If minor, Legal Guardian)

Medical Record Number:_____

To whom it may concern,

I, _____verify that I am:
(Patient name)

(Check all that apply)

- ☐ Currently Unemployed
- ☐ Currently not receiving Unemployment Benefits
- ☐ Currently not receiving Social Security, Disability, or Retirement Benefits.

_____

Patient Name (*print*)

_____ _____

Patient Signature **Date**

_____ _____

NCFMC STAFF Signature **Date**