Rural Health Medical Program, Inc.

Application for the Sliding Fee Program

Please complete the sliding fee application with proof of income.

The sliding fee program is not considered Insurance/healthcare coverage. The sliding fee program provides approved patients a reduced fee for services received at our offices throughout the surrounding counties in the Black Belt area. If you have any questions or need assistance with the application, please speak with any of our front desk staff team members.

Requirements of Income:

Employment **(Proof of income is required)**	• 1 month of most recent paystubs • Recent Tax Return or W2 • Letter from employer stating gross wages on letter head or notarized letter.
Self-Employment	• Recent Tax return with schedule C
Disability / Social Security	• Official benefit letter
Child Support / Alimony	• Official letter or court order
Government Assistance	• Official benefit letter
Pensions	• Official benefit letter
If claimed on someone else's Tax Return	• Current tax return
No Income	• 100% of charges will be required

RURAL HEALTH MEDICAL PROGRAM, INC.
Providing Quality Healthcare Services Since 1977.

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SLIDING FEE APPLICATION

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed, dated and submitted to the receptionist, along with **paystubs from the last 30 days for all the people in the household or last year's Income Tax Return.**

Head of Household Name (Last, First):_______________________________Phone_____________________
Address:_______________________________City_________________State________ Zip code _______

Household Size:

"Household" is considered as all persons living with you at the same address. If living situation is temporary, please advise staff of your situation. List all household members by NAME, DATE OF BIRTH AND RELATIONSHIP, include yourself:

Name:	*Date of Birth:*	*Relationship:*
		(SELF)

Sources of Income:

List sources of income for all members living in the household.

Source	*Amount*	*Weekly*	*Bi-Weekly*	*Monthly*	*Annually*
Salaries and Wages (self)	________	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (spouse)	________	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (other)	________	[ ]	[ ]	[ ]	[ ]
Workmen's Comp (SIIS)	________	[ ]	[ ]	[ ]	[ ]
Social Security (Self/Spouse)	________	[ ]	[ ]	[ ]	[ ]
Social Security (Children)	________	[ ]	[ ]	[ ]	[ ]
SSI (Supplemental Security)	________	[ ]	[ ]	[ ]	[ ]
Child Support/Alimony	________	[ ]	[ ]	[ ]	[ ]
Military/Veteran Benefits	________	[ ]	[ ]	[ ]	[ ]
Unemployment Benefits	________	[ ]	[ ]	[ ]	[ ]
Other Family Members	________	[ ]	[ ]	[ ]	[ ]

PLEASE READ THE FOLLOWING CAREFULLY!!

I, the undersigned, have completed this application for Sliding Fee eligibility and confirm that this information is true and correct, to the best of my knowledge. I understand that any change in financial status or the number of people in my household must be reported to Rural Health Medical Program, Inc. and a new application must be completed. I further understand that, upon request there will be an annual review of my application with the possibility of changes. I understand any falsifications or the failure to report any changes may result in my being made ineligible for the Sliding Fee adjustments made available by Rural Health Medical Program, Inc.

Applicant's Signature: ____ Date: _____________

OFFICE USE ONLY

Received by: _________________________ Date: ________________ SF Category: ______________________________
Approved or Denied: ______________________ Expiration Date: ________________ Approved by: __________________

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