MOREHOUSE COMMUNITY MEDICAL CENTERS, INC

Sliding Fee Application

Name: _____ **Spouse Name:** _____

Phone Number - Home _____ **Spouse Work #** _____

Work _____

Address: _____

Household members:

Name	Date of Birth	Name	Date of Birth

Income for Each Household Member

Name	Gross Amount (Before Taxes)	Type of Income	Frequency (ie: monthly, weekly, bi-weekly)

Do you have ANY insurance coverage including Medicare or Medicaid? Yes: ___ No: ___

Company Name:	**Policy Number:**
Type of Coverage (circle all that apply) A. Hospital B. Prescriptions C. Dr. Visits D. X-rays E. Lab work F. Medicare Supplement G. In patient only H. Outpatient I. Dental J. Indemnity	
Medicare #	**Check all that apply: Type A __ Type B __ Type A & B __**
Medicaid #	**If Medicaid is pending, date applied:**
Signing a false or knowingly incorrect application will render you ineligible for the sliding fee programs for the duration of your care at any facility operated by Morehouse Community Medical Centers, Inc.	

Signed_____ _____ **Date:**_____

Witness: (If signed with and X) _____ **Date** _____

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For Office Use Only: **Income documentation attached: Yes No**

Total yearly household income: _____ **Household size:** _____

Approved for sliding fee: Yes No **Staff Signature:** _____ **Date:** _____

Slide: Minimum Fee $10 20% 40% 60% 80%

If sliding fee denied, reason: _____