FREDERIKSTED HEALTH CARE, INC

SLIDING FEE APPLICATION

Office Use Only: Annual Household Income: $_____
Family Size:_____
☐ Qualify for Discounts
Authorization: From:_____To:_____
☐ Not Eligible for Discounts
☐ Insufficient Information
FHC-Staff:_____

Head of Household:_____Date of Birth:_____ Sex: ☐ F ☐ M
Mailing Address:_____City:_____Zip Code:_____
Home Address:_____City:_____
Telephone #:_____Work:_____ Cell:_____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorce ☐ Separated

Please list spouse and dependents under age 18:

NAME	SEX	DOB	RELATIONSHIP	PATIENT	WORKING
1._____	M F	___/___/___	_____	YES NO	YES NO
2._____	M F	___/___/___	_____	YES NO	YES NO
3._____	M F	___/___/___	_____	YES NO	YES NO
4._____	M F	___/___/___	_____	YES NO	YES NO
5._____	M F	___/___/___	_____	YES NO	YES NO
6._____	M F	___/___/___	_____	YES NO	YES NO

List all sources of income for each member of the family. Include wages, alimony, child support, veteran's benefits, unemployment benefits, social security benefits, pensions, public assistance.

AMOUNT	PAY FREQUENCY	SPECIFY SOURCE OF INCOME	PAID TO
$_____	Wkly Bi-wkly Monthly Yearly	_____	_____
$_____	Wkly Bi-wkly Monthly Yearly	_____	_____
$_____	CHILD SUPPORT Monthly	_____	_____
$_____	**TOTAL INCOME**	**Do you receive FOOD STAMPS? ☐ YES ☐ NO**	

Are you covered by any of the following insurance?: ☐ YES ☐ NO

Private Insurance:_____Group #:_____ Policy #:_____
Medicare: Policy #:_____Effec. Date:_____Exp. Date:_____
Medical Assistance Program (MAP):#_____ Effec. Date:_____Exp. Date:_____

Name of Policy Holder:_____ DOB: ____/____/____ SS#:_____

The information I have provided concerning the size of my household/family and my gross annual income from all sources is true, accurate, and complete to the best of my knowledge. I understand that this information will be kept in strict confidence. I grant permission to Frederiksted Health Care, Inc to investigate any information given in this application and I understand that knowingly giving false information may result in Federal prosecution. I agree to report any changes in either my income or family size to Frederiksted Health Care, Inc.

My signature below indicates that all information I have provided is true to the best of my knowledge.

Household Signature:_____ Date:_____