WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

APPLICATION FOR THE SLIDING FEE SCALE

Date of application: _____

Patient's Name: _____ Date of Birth_____
Last First Middle

Address_____

_____
City State Zip Code

Has lived at this address since: _____(Date)

Telephone number ___ (___) _____

Cell Phone number ___ (___) _____

Are you currently a patient in more than one of our centers? Yes_____ No _____

If so, please specify which centers:
_____

Occupation: _____

Employer: _____

Do you currently have any medical insurance? Yes_____ No _____

If yes please complete the following information: (medical)
Name of insurance: _____
Policy number: _____
Policy holder's name: _____Date of Birth: _____

Do you currently have any dental insurance? Yes_____ No _____

If yes please complete the following information: (dental)
Name of insurance: _____
Policy number: _____
Policy holders name: _____Date of Birth:_____

HOUSEHOLD MEMBERS (LIST ONLY THOSE WHO ARE ON YOUR INCOME TAX RETURN)
*ALL OTHER MEMBERS IN HOUSEHOLD NEED TO APPLY SEPARATELY

Name **Date of Birth** .

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

INCOME: List **ALL Household income** for the following sources:
Please provide a copy of your most recent income tax return. If you have a change in financial Circumstance since the last income tax return, please provide documentation of current income or financial status.

	Total for 12 months
Wages	_____
Social Security	_____
Farm or Self-Employment	_____
Public Assistance (SNAP)	_____
Alimony	_____
Military Pensions	_____
Pension	_____
Dividend or Interest Income	_____
Rental Income	_____
Unemployment	_____
Total	_____

Change of Circumstances: Since the date that you filed your last income tax return, has your income changed drastically? Have you had a change in your financial circumstances?
Please write a detailed note about the way it has changed._____
_____
_____
_____

I affirm that the above information is true and correct to the best of my knowledge.

_____ _____
Date Signature

_____
Relationship to patient(s)

Revised 08/26/2008, 01/05/2009, 03/16/2009, 11/10/2010, 01/06/2011.10/17/2011,11/15/2011,07/02/2014