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 married? Yes_____ No _____

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 holders 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:

Do you file a tax return? Yes_____ No _____

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 Last 12 months
Wages	_____
Social Security	_____
Farm or Self-Employment	_____
Public Assistance	_____
Strike Benefits	_____
Alimony	_____
Military Family Pensions	_____
Pensions	_____
Dividend or Interest Income	_____
Rental Income	_____
Other	_____
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)