

Sliding Fee Discount Application

HARRIS
MEDICAL ASSOCIATES

HARRIS
PEDIATRIC CARE

SWAIN
FAMILY CARE

HARRIS
WOMEN'S CARE

It is the policy of Western Carolina Physician Practice Management, LLC., NHSC approved sites to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 6 months or if your financial situation changes.

PATIENT NAME:		DATE OF BIRTH:	
STREET ADDRESS:	CITY:	STATE:	ZIP:
SOCIAL SECURITY NO:	TELEPHONE:		
NAME OF HEAD OF HOUSEHOLD (HOH):	HOH PLACE OF EMPLOYMENT:		

Please list Head of household, Spouse and Dependents under the age of 18

SELF: _____

DATE OF BIRTH: _____

SPOUSE: _____

DATE OF BIRTH: _____

DEPENDENT 1: _____

DATE OF BIRTH: _____

DEPENDENT 2: _____

DATE OF BIRTH: _____

DEPENDENT 3: _____

DATE OF BIRTH: _____

DEPENDENT 4: _____

DATE OF BIRTH: _____

DEPENDENT 5: _____

DATE OF BIRTH: _____

DEPENDENT 6: _____

DATE OF BIRTH: _____

DEPENDENT 7: _____

DATE OF BIRTH: _____

Annual Household Income:

<u>INCOME SOURCE:</u>	GROSS WAGES, SALARIES, TIPS, ETC.	INCOME FROM BUSINESS, SELF-EMPLOYMENT, AND DEPENDENTS	UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, PUBLIC ASSISTANCE, VETERANS' PAYMENTS, SURVIVOR BENEFITS, PENSION OR RETIREMENT INCOME	INTEREST, DIVIDENDS, RENTS, ROYALTIES, INCOME FROM ESTATES, TRUSTS, EDUCATIONAL ASSISTANCE, ALIMONY, CHILD SUPPORT, ASSISTANCE FROM OUTSIDE THE HOUSEHOLD, AND OTHER MISCELLANEOUS SOURCES.
SELF:				
SPOUSE:				
ALL DEPENDENTS:				
TOTAL:				

REQUIRED INFORMATION FOR VERIFICATION:

1. PRIOR YR W-2, TWO MOST RECENT PAY STUBS, LETTER FROM EMPLOYER, OR FORM 4506-T (IF W-2 NOT FILED)
2. TWO FORMS OF IDENTIFICATION/ADDRESS
(STATE ISSUED PHOTO ID, UTILITY/TELEPHONE BILL)

RETURN THIS APPLICATION TO:

WCPP CENTRAL BUSINESS OFFICE
 ATTN: FINANCIAL ASSISTANCE DEPT. 13
 HAYWOOD OFFICE PARK, SUITE 106B
 WAYNESVILLE, NC 28785

I certify that the family size and income information shown above is correct.

NAME (PRINT): _____

SIGNATURE: _____

DATE: _____

Office Use Only

VERIFICATION CHECKLIST	YES	NO
Prior yr W-2 or Tax Return, Two most recent pay stubs, Letter from Employer, or Form 4506-T.		
Identification/Address - forms used.		
If Self Employed, Business Income & Expenses for most recent 3 months.		
Insurance: Insurance Cards		

PATIENT NAME: APPROVED DISCOUNT %: APPLICATION VERIFIED BY: CFO APPROVAL:	NOTES:
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