DECLINE:________
(CHECK HERE IF YOU DECLINE)

SLIDING FEE DISCOUNT PROGRAM APPLICATION
SOUTHWEST GEORGIA HEALTHCARE CLINICS, INC.

____
Signature for Decline

PATIENTS NAME:________________________DATE:____________________

RESPONSIBLE PARTY NAME:____

LIST OF ALL PERSONS LIVING IN HOUSEHOLD OF REPSONSIBLE PARTY:

NAME	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER**

HOUSEHOLD INCOME

SOURCE	**MEMBER A**	**MEMBER B**	**MEMBER C**	**MEMBER D**	**MEMBER E**	**TOTAL**
Employment Earnings						
Social Security						
Retirement Pension						
Child Support						
Alimony						
Other Sources						
Total						

-Note: Annual Household income is defined as income for **all members of the household** including gross wages, not earning from self-employment or business, tips, social security, disability payments, pension, annuities, veteran's benefits, alimony, child support, military, unemployment, public aid and any other source of income providing payments to members of household. Documentation is required to determine annual household income. This can include tax returns, W-2's, payroll stubs (2 most recent if paid every 2 weeks or 4 most recent if paid weekly), social security statement, or retirement statement**. If you are currently unemployed, you will need 3 letters from 3 different people** (**who are not related to you**) stating that they know you are currently unemployed. **You will have 30 days from the date of service, to bring back the necessary documentation**. If you fail to do so, the application will automatically expire in the system and will result in you paying the full amount for your office visits. This covers office visits only. This does not cover hospital stays.

-Number of persons in household__________________________Annual household income $____________________
-I do understand that I am required to pay a nominal charge of discounted fee for services depending upon the slide discount level for which I am eligible. If I do not provide this application timely, I will be responsible for full payment for office visits.
-I certify that I am seeking to participate in the Sliding Fee Discount Program offered by Southwest Georgia Healthcare Clinics, Inc. for services based on information I have provided. The information I have provided is true and correct and that legal action can be taken for providing false information.

____ ____________________________________
Responsible Party's Signature Date Time

YOU MUST TURN THIS APPLICATION INTO SOUTHWEST GEORGIA HEALTHCARE CLINICS, INC.
NO LATER THAN 30 DAYS FROM THE DATE OF SERVICE.

SWGA-HCC Use:

SWGA – HCC Staff Signature Date Time