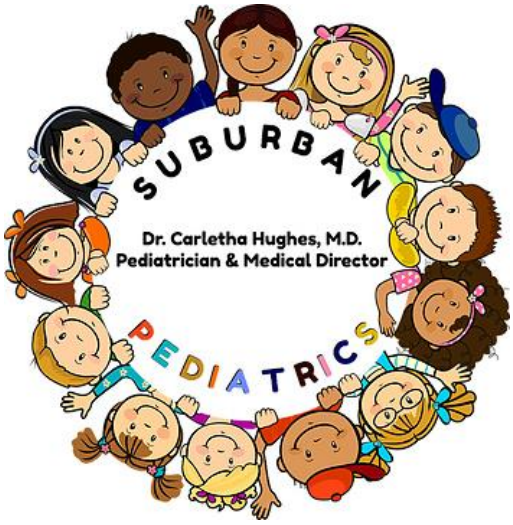

SUBURBAN PEDIATRICS MEDICAL CENTER SLIDING FEE APPLICATION

Dear patient, we care about your child's health. It's our policy to provide essential healthcare services regardless of your ability to pay. **Discounts are offered based on family size and annual income.** Please complete this application to determine if you are eligible for discounted services.

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 annually or if your financial situation changes. Thank you.

HEAD OF HOUSEHOLD			WHERE DO YOU WORK?	
ADDRESS	CITY	STATE	ZIPCODE	PHONE

Please tell us more about your family.

NAME	BIRTHDATE	NAME	BIRTHDATE
YOU		CHILD #3	
PARTNER/SPOUSE		CHILD #4	
CHILD #1		CHILD #5	
CHILD #2		CHILD #6	

August 2017

HOUSEHOLD YEARLY INCOME

SOURCE OF INCOME	SELF	SPOUSE PARTNER	OTHER	TOTAL
WAGES, TIPS, ETC.				
BUSINESS-RELATED INCOME, FROM OTHER SOURCES				
WORKERS COMP, SSI, SURVIVOR BENEFITS, VETERANS PAYMENTS, PUBLIC ASSISTANCE, SURVIVOR BENEFITS, ETC.				
INTEREST, RENT, OTHER MISCELLANEOUS SOURCES OF INCOME				
TOTAL INCOME				

We will require pay check stubs or other forms to verify your income before the discount can be approved.

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

Print name _____

Please sign _____ **Date** _____

Suburban Pediatrics Medical Center Office Use Only

DATE: _____

PATIENT: _____

APPROVED DISCOUNT: _____

APPROVED BY: _____

APPROVED VERIFICATION CHECKLIST	YES	NO
ID w/Address: Driver's license, job ID, utility bill, etc.		
Income: Tax return, 3 RECENT pay check stubs, etc.		
Insurance: Insurance card		