Med Center Health.

Sliding Fee Schedule Application:

Please fill out the application for Financial Assistance completely. The below items will need to be returned with the application to determine your household income and if you qualify for financial assistance:

Proof of income for your and each person in your household, such as copies of pay stubs showing year-to-date income totals, copies of social security benefits, alimony checks, and your most recent income tax return with W2's. Please see the Financial Assistance Policy: Rural Health Clinics for a complete definition of Income.

Please remember to send copies and not originals. If you or your family participates in either Medicaid or Food Stamps, please send us proof of your participation. If you or your spouse are not working, please send a notarized statement explaining your situation and the time period involved. If you have any questions regarding the application, you can contact our offices at 270-745-1100. Our business hours are Monday thru Friday 8:00 am to 4:30pm.

Date:

Name:		
Address:		
City:	**State:**	**Zip:**

Please list all dependents in the household:

Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**

Please list the total annual household income:

Gross Wages, salaries, tips, etc.:
Spouse's wases, salaries, tips, etc. :
All other forms of Income:
Total income:

I certify that all information contained in this application is correct.

Signature:	**Date:**