Application for Sliding Fee/Charitable Care

Name____________________ Social Security Number______________________ Date of Birth________________

Spouse Name________________________ Social Security Number___________________ Date of Birth_________

Address____ Phone Number___________________________

City, State, Zip____ Cell Phone_____________________________

Dependents' Name_____________________ DOB_______ Dependents' Name_____________________ DOB_______

Dependents' Name_____________________ DOB_______ Dependents' Name_____________________ DOB_______

Income Verification

Please attach copies of W-2s, current tax return or paystubs for at least three months to this application for all working members in your household. Failure to do so will result in denial of application.

Self

Employer____________________________________

Address_____________________________________

Phone Number_________________________

Monthly Gross Income___________________

Other Monthly Income___________________

Other Monthly Income___________________

Spouse

Employer _____________________________________

Address_______________________________________

Phone Number_________________________

Monthly Gross Income___________________

Other Monthly Income___________________

Other Monthly Income___________________

(Welfare, SSI, Child Support, Workman's Comp., Unemployment, Pensions, Rents, Alimony, Veteran's Survivor Benefits, Retirement)

Do you have a Health Savings Account (HSA) and/or Flexible Spending Account? Yes No

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by SRMC Physicians Clinic. I hereby grand permission to SRMC Physicians Clinic to investigate the information contained therein.

Signature_________________________________

Date__________________

Signature_________________________________

Date__________________

Please print completed form and mail or deliver to:
SRMC Physicians Clinic
1000 Pole Creek Crossing
Sidney, NE 69162
(308) 254-5544