A partnership with Tallahassee Memorial HealthCare

Doctors' Memorial Clinic's

Slide Fee Discount Application

Please check one: ________ Perry ______Mayo ______Steinhatchee

Sliding Fee Discount Information

It is the policy of Doctors' Memorial Clinics to provide essential services regardless of the patient's ability to pay. Doctors' Memorial Clinic's offers discounts 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 purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. You MUST complete this form every 12 months, or if your financial situation changes.

<table>
<tr><td colspan="4">NAME OF HEAD OF HOUSEHOLD</td><td>PLACE OF EMPLOYMENT</td></tr>
<tr><td>STREET</td><td>CITY</td><td>STATE</td><td>ZIP</td><td>PHONE</td></tr>
</table>

Please list name of spouse and dependents under age 18.

Self_______________________________ Date of Birth _______________

Spouse _____________________________ Date of Birth _______________

Dependent __________________________ Date of Birth _______________

Dependent __________________________ Date of Birth _______________

Dependent __________________________ Date of Birth _______________

Dependent __________________________ Date of Birth _______________

Dependent __________________________ Date of Birth _______________

Dependent __________________________ Date of Birth _______________

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, ect				
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				
Interest, dividends, rents, royalties, income from Estates, trust, education assistance, alimony, child Support, assistance from outside the household, and Other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved.

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

Name ____

(Print)

Signature ____

Date ________________________

OFFICE USE ONLY

Patient Name: ____

Approved Discount: ____

Approved by: ____

Date Approved: ____

Verification Checklist

Identification/Address: Driver's License, utility bill, employment ID	**Yes ___**	**No ____**
Income: Prior year tax return, three most recent pay stubs, or other	**Yes ___**	**No ____**
Insurance: Insurance Cards	**Yes ___**	**No ____**