**GROVE HILL HEALTHCARE**

(An affiliate of Grove Hill Memorial Hospital)

**SLIDING FEE ELIGIBILITY WORKSHEET**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the head of the family: \_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_\_ NO

Total number in family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names of all in family: (List First and Last Name)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

Do you have Medicaid? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

Did you apply for Medicaid? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

Do you have Medicare? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

Are you employed? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

What is your monthly household income? $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\*\*\*GROSS INCOME)

Verified By:

Salary or Wages: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pay Stub, Letter Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unemployment: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check Stub, Letter Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pension: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rent Received: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dividends/Interest: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workers Comp: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alimony: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Support: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Training Allowance: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private Support: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I CERTIFY THAT I HAVE LIMITED MEANS OF PAYING FOR MEDICAL SERVICES AND THAT THE INFORMATION PROVIDED ABOVE IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO PROVIDE ACCEPTABLE DOCUMENTATION AS PROOF OF MY \*\*\*GROSS HOUSEHOLD INCOME. I ALSO AUTHORIZE THIS CLINIC TO DISCLOSE THIS INFORMATION TO THIRD PARTY PAYERS AND OTHER HEALTHCARE PROVIDERS AS NECESSARY TO QUALIFY ME FOR REDUCED FEES FOR OUTSIDE SERVICES (LABS, ETC.).**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Clinic Representative) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

QUALIFIED: \_\_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_ PENDING