Name:	
Address:	
City, State:	
Zip Code:	
Telephone:	
Social Security #:	
Date of Birth:	
Chart Number:	

Enterprise Valley Medical Clinic

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on your medical expenses. This information will be kept on file in our clinic in strict confidence You must verify your income once a year. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past six months, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: _____

Number of people living in your home? _____

What is your marital status? ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

Do you own or rent your home? ☐ Own ☐ Rent ☐ Live with Someone

Amount of Family Income?

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment?

You	Your Spouse	Your Children	Other Person

Do you have money in your savings account? $ _____   Do you have any rental property? Yes ☐ No ☐

Do you have money in a checking account? $ _____   Do you own stock or certificates? Yes ☐ No ☐

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

Do you have any type of insurance that will cover a portion of your medical expense? Yes, list below ☐   No ☐

Give names, addresses and or phone numbers of two people other than family members who can verify your income.

Name:	Name:
Address:	Address:
City, State:	City, State:
Phone Number:	Phone Number:

I declare the above information is true and have given Enterprise Valley Medical Clinic permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature:	Date:	*Clinic Purpose Only* Income Code: