HRN: ___________

SLIDING FEE DISCOUNT ELIGIBILITY DETERMINATION

PATIENT NAME: ______________________________ PATIENT DOB: _______________

PARENT OR GUARDIAN NAME: ____
(If under the age of 18)

INCOME SOURCE (Check all that apply):

Paycheck Stub	
Food Stamps	
Worker's comp	
Child Support	
Alimony	
W2	
Income Tax Return	
TANF Benefits	

Self-Employment	
Unemployment	
Social Security	
Working for cash	
Other forms of income: *Please Specify:*	
No Income	

Do you have any type of insurance that will cover all or a portion of your healthcare expense? ***(Check all that apply)***

Medicare: _________ Medicaid or KanCare:___________ Private Insurance ____________

I do not have insurance: __________

Please answer all questions below:

Household Family Size: _______

Marital Status: __________

Estimated Spouse Income: ___________

I am an American Indian or Alaska Native with tribal identification: ________

I work in Agriculture: ______________ If yes, please list your employer: __________________

I am currently living at a homeless shelter: ___________ Name of Shelter: _________________

I declare the above information is true and give Hunter Health permission to investigate any information on this application. I understand that if my income should change that I am required to notify Hunter Health on my next visit.

Signature: _______________________________________Date: ________________________

Office Use Only: Family Size__________ Gross Income: __________ Weekly/ Bi-weekly/ Monthly
(52) (26) (12)

Annual Income: ___________________ Slide Assignment: ___________ Expires:_________________

Date Application Completed: _________________ Date Documents Received: _________________

Application Completed By (Staff): ____