WHITE MOUNTAIN REGIONAL MEDICAL CENTER RURAL CLINIC

White Mountain Regional Medical Center, RHC Sliding Fee Scale Application

Thank you for completing the information below, in addition to the completed form, we will need a copy of last year's tax return, W2's, and 2 recent pay stubs. Please return your application and supporting documentation as soon as possible to ensure timely processing.
Discounts only apply to office visits and procedures. This discount does not apply to third parties such as outside laboratory services or medical equipment.

Name of Head of Household _____

Mailing Address_____City _____State _____Zip_____

Physical Address_____ City _____State _____Zip_____

Phone _____Cell Phone_____

Email Address _____

Please List Spouse and dependents under the age of 18

	Name	Date of Birth		Name	Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

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Source	Self	Spouse	Other	Total
Gross wages from salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensations, workers' compensation, Social Security, SSI, public assistance, veteran's payments, survivor benefits, pension, or retirement				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

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

Name (Print) _____

Signature_____ Date _____

☐ **Proof of Income Attached**

Office Use Only

Total Annual Income Number in Family

Verification Checklist	Yes	No
Identification/Address: DL, Utility bill, etc	☐	☐
Income: Prior year tax return and 2 most recent pay stubs, or other	☐	☐
Insurance: Insurance Cards	☐	☐

Percent of fees patient pays _____ % Date determination letter sent _____

Authorization Level I _____ Date _____

Authorization Level II _____ Date _____