Miners' Colfax Medical Center

Application for Sliding Fee

Today's date: _____

Head of household:

_____ _____ _____

Last Name First Name MI Social Security no.

_____ _____

Street Address Date of Birth

_____ _____ _____

City State Zip Home Phone no.

Head of household gross monthly income: $_____

Other family members:

Name	Date of birth	Gross monthly income
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

For additional family member(s) please use the back of this form.

Total family gross monthly income: $_____

Total family members: _____

By signing this form, I attest to the truthfulness and completeness of all information requested.

_____ _____

Signature Date

DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)

Proof of income documents received:

☐ Pay stubs ☐ Prior year tax returns ☐ Social Security determination letter

☐ Bank deposits ☐ Statement of sustainability

A copy of each document must be attached to this application.

Eligible for discount of: _____% Beginning: _____ Ending: _____

_____ _____

Signature of staff Date

Miners' Colfax Medical Center

Financial Disclosure – Confidential

(To be completed in full) **LIABILITIES**

List names of Firms	Unpaid Balance	Monthly Payment
Rent ____ Own ____		
Bank Loans		
Finance Companies		
Credit Union Loans		
Medical Expenses		
Personal Loans		
Collection Agencies		
Charge Accounts/Credit Cards		
Expenses:		
Food		
Utilities		
Phone		
Auto Expenses		
Health Insurance		
Auto Insurance		
Child Care		
Miscellaneous (please describe)		

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services, which are rendered to me by Miners' Colfax Medical Center. I hereby grant permission to Miners' Colfax Medical Center to receive, release, or act upon financial information, to investigate the information contained herein. Investigation shall contain contacting, by written communication or telephone, of those persons, firms, corporations, etc. noted by you on this financial information document. Investigation may also include a credit check. I hereby release the designated clinic personnel and all parties who supply information at the request of the clinic personnel from liability for any acts of commission or omission, communications or disclosures that are made pursuant to such an investigation. I understand that submission of false information will automatically disqualify me for any type of assistance.

Responsible Party Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Name	Date of birth	Gross monthly income
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

Statement of Sustainability

Please fill out this statement of sustainability if you cannot provide any proof of income. Please indicate how persons with no income are meeting their day to day basic living needs. This will enable Miners' Colfax Medical Center to process your sliding fee application.

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_____ _____

Signature Date