SUMTER FAMILY HEALTH CENTER

1278 N. Lafayette Drive Sumter, SC 29150

Sliding Fee Scale Application

(Please Return This Application within 10 Days to Avoid Denial of Application)

Name: _____ Social Security Number: _____-___-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No:(_____)_____-_____ Alternate No:(_____)_____-_____

Monthly Household Income: $_____ **Family Size**: _____

Please list all household members, age, and work/school status. ***Be sure to include yourself.***

	Name:	**Age:**	**Work/School:**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

The following items must be brought in to determine eligibility:

Income Documentation
(Please Check All That Apply)

- Last two (2) Payroll Check Stubs: ☐ YES ☐ NO
  Date: ____/____/____ Weekly $_____
  Bi-weekly $_____
  Monthly $_____
- Proof of all household income by any other source (child support, etc.): ☐ YES ☐ NO
- Public Assistance Award Letter: (Housing, Food Stamps, etc.) ☐ YES ☐ NO
- SS √ Stub or Benefits Statement: ☐ YES ☐ NO
- Other (Migrant Worker, etc.):_____

_____
_____
_____

Identification Documentation
(Two items required)

- Social Security Card (see above): ☐ YES ☐ NO
- Birth Certificate: ☐ YES ☐ NO
- Picture ID: ☐ YES ☐ NO
- Voter Registration: ☐ YES ☐ NO
- Visa/Work Permit: ☐ YES ☐ NO
- Passport: ☐ YES ☐ NO
- Other: ☐ YES ☐ NO

_____
_____
_____
_____

SFHC Medical Record No:_____

Regardless of discount determined, a Nominal Fee is required at the time services are rendered.
If you do not provide the appropriate documentation you are responsible for the entire amount of the "BALANCE DUE".
In compliance with Federal laws, I certify that the information I have submitted it TRUE.

Applicant's Signature: _____ Date: _____

SFHC Use Only

Approved: _____ Level: _____ Not Approved: _____ Review Date: _____ Reviewed By: _____

Date: _____