Sliding Fee Discount Program Application

Primary Care of Southwest Georgia, Inc.

Patient's Name: _____

Responsible Party Name:_____

List all Persons living in household of responsible party

Name	Date of Birth	Social Security Number

Household Income

Source	Member A	Member B	Member C	Member D	Member E	Total
Employment Earnings						
Social Security						
Retirement Pension						
Child Support						
Alimony						
Other Sources						
Total						

Note: Include income from all sources including gross wages, net earnings from self employment or business, tips, social security, disability payments, pension, annuities, veteran's benefits, alimony, child support, military, unemployment, public aid and any other source of income providing payments to members of household. Proof of income must be provided and may include tax returns, payroll stubs, and attestations by persons making payments to household members or other documents.

Number of persons in household: _____ **Annual household income**: **$**_____

I do understand that I am required to pay a nominal charge for services depending upon the slide discount level for which I am eligible.

I certify that I am seeking to participate in the Sliding Fee Discount Program offered by Primary Care of Southwest Georgia for services based on information I have provided. The information I have provided is true and correct and that legal action can be taken for providing false information.

_____ _____

Responsible Party's Signature **Date**

PCSG USE:

Employee accepting application:_____

Signature **Date**