Date Received: _____

Staff Initials: _____

North Florida Medical Centers, Inc.

APPLICATION FOR SLIDING FEE

DUE BY: _____

Patient Name: _____ _____
(Last) (First) (Middle) (Acct #)

Guarantor Name: _____ _____
(Last) (First) (Middle) (Acct #)

Guarantor Mailing Address: _____
(Street or Box #) (City) (State) (Zip) (County)

Guarantor Married Status: _____Single _____Married _____ Divorced _____Separated _____ Widowed

Guarantor Birth date: ____ / ____ / _____ Age: _____ Sex: ____F ____M
(month) (day) (year)

Guarantor Social Security # _____ Phone (Home) _____

Is Guarantor Employed? YES ____ NO _____ Occupation: _____

Employer's Name: _____ Phone: _____

Address: _____

Do you have any of the following? 1. Insurance _____ 2. Medicare _____ 3. Medicaid _____
(Yes/No) (Yes/No) (Yes/No)

FAMILY UNIT

(Notate beside names which type of coverage(s) apply)

Name	Type of Coverage	Relationship to Patient	Date of Birth	Sex

(Please list any additional members on the back of the form)

INCOME (All Sources Must be Included)

	Hours Per Week	Per Hour Rate	Weekly Rate	Monthly Rate	Yearly Rate
Head of Household					
Spouse					
Other					
Other					

TOTAL FAMILY MEMBERS:_____ TOTAL ANNUAL INCOME: $_____SLIDE FEE RANK: _____

By signing my name to this form, I am certifying the information given is true, accurate and complete to the best of my knowledge. I understand if I provide false information, I am liable for prosecution under State and/or Federal law. I give consent to NFMC to verify the information on this application. I understand this application must be renewed in 12 months from application date, unless indicated otherwise by Center Manager.

_____
Patient/Guardian Signature

☐ **DECLINED**

_____ / _____ / ____
Application Date

_____
Interviewer

_____ / _____ / ____
Assessment Date