Application for Sliding Fee/Charitable Care

Name_____Social Security Number_____Date of Birth_____

Spouse Name_____Social Security Number_____Date of Birth_____

Address_____Phone Number_____

City, State, Zip_____Cell Phone_____

Dependents' Name_____DOB_____Dependents' Name_____DOB_____

Dependents' Name_____DOB_____Dependents' Name_____DOB_____

Income Verification

Please attach copies of W-2s, current tax return or paystubs for at least three months to this application for all working members in your household. Failure to do so will result in denial of application.

Self_____ Spouse _____

Employer_____ Employer _____

Address_____ Address_____

Phone Number_____ Phone Number_____

Monthly Gross Income_____ Monthly Gross Income_____

Other Monthly Income_____ Other Monthly Income_____

Other Monthly Income_____ Other Monthly Income_____

(Welfare, SSI, Child Support, Workman's Comp., Unemployment, Pensions, Rents, Alimony, Veteran's Survivor Benefits, Retirement)

Do you have a Health Savings Account (HSA) and/or Flexible Spending Account? Yes No

I certify that the above information is true and accurate to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for the services provided by SRMC Physicians Clinic. I hereby grand permission to SRMC Physicians Clinic to investigate the information contained therein.

Signature_____ Signature_____

Date_____ Date_____

Please print completed form and mail or deliver to:

SRMC Physicians Clinic
1000 Pole Creek Crossing
Sidney, NE 69162
(308) 254-5544