Appt. Date: _____

Notes:

WELL CARE COMMUNITY HEALTH
203 EAST MAIN STREET
RICHMOND, IN 47374

SLIDING FEE ELIGIBILITY FORM

Today's Date: _____

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
EMR #:

It is necessary for us to ask personal questions to give you a discount on our medical expenses. This information will be kept on file in our Health Center and held in strict confidence You must verify your income at least annually. Your yearly income can be verified by one of the following: tax return, copy of your two (2) current pay stubs (within the past 3 months), disability check stub, SSI check stub, current unemployment check stub/statement, or child support check stub. Your annual income will be used to calculate the level of your payment.

Number of people living in your home? ☐

What is your marital status? ❑ Married ❑ Widow(er) ❑ Single ❑ Divorced ❑ Separated

Amount of Household Income:

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment:

You	Your Spouse	Your Children	Other Person

Do you receive any income from any of the following sources, and if so, how much?

Source	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					

Do you have any type of insurance that will cover all or a portion of your medical expense? ❑ Yes, list below ❑ No

Give Names, DOB, and relationship of all individuals living in the household:

Name	Date of Birth (DOB)	Relationship to patient

I declare the above information is true and have given the Well Care Community Health, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature: Print:	Date:	***Clinic Purpose Only:*** Income Code: