Boyd Fillager Clinic

Greene County Rural Health Clinic

Rural Health Center of Roodhouse

Thomas H. Boyd Memorial Rural Health Clinic

Sliding Fee Discount Application

It is the policy of Thomas H. Boyd Memorial Hospital’s rural health clinics (Boyd Fillager Clinic, Greene County Rural Health Clinic, Rural Health Center of Roodhouse and Thomas H. Boyd Memorial Rural Health Clinic) to provide essential services regardless of the patient’s ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from the outside, including reference laboratory testing, drugs, and x-ray interpretation by our consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Head of Household

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment Phone number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

**Please list spouse and dependents under age 18.**

Name Date of Birth Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self Spouse

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dependent Dependent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dependent Dependent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dependent Dependent

Sliding Fee Discount Program for Rural Health Clinics Application

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Source Self Spouse Other Total

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Income from business, self-employment, and  dependents |  |  |  |  |
| Unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veteran’s payments, survivor benefits, pension or retirement income |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources |  |  |  |  |
| **TOTAL INCOME** |  |  |  |  |

**Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.**

**I certify that the family size and income information shown above is correct.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Name

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date