

Cold Hollow Family Practice, P.C.

Sliding Fee Schedule Discount Application

Cold Hollow Family Practice, P.C. is committed to providing essential services in our clinic regardless of your ability to pay. We offer discounts based on your family size and annual income.

We invite you to complete the form below so we can determine the level of your discount. The discount will apply only to services received at this clinic, but not services or equipment purchased from another provider, including our outside reference lab, medications, x-ray and other diagnostics and other doctors and providers. There are pharmaceutical programs and hospitals offer discounts, and we can provide information about how to apply for these.

Please complete this form every 12 months, or if your family's financial situation changes. For the
purposes of this application, a family is defined as a group of two people or more (one of whom is the
householder) related by birth, marriage, or adoption and residing together; all such people (including
related subfamily members) are considered as members of one family. Clinic will also accept non-related
household members who are dependents when calculating family size.

| Patient Name: | Last four digits of SSN: |
|----------------------|--------------------------|
| Mailing Address: | |
| Date of Application: | Reviewed by: |

Please list all family members, including those under age 18:

| Relationship | Name | Date of Birth |
|--------------|------|---------------|
| Self | | |
| | | |
| | | |
| | | |
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| | | |
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Please list the annual income and all sources of income for the whole family:

| Source | Self | Others | Total |
|---|---------------------------|--------|-------|
| Gross wages, salaries, tips, commissions, etc. | | | |
| - · · · · · · · · · · · · · · · · · · · | | | |
| Income from business and self-employment | | | |
| | | | |
| Unemployment, workers' compensation, Social Security, | | | |
| Supplemental Security Income, veterans' payments, survivor | | | |
| benefits, pension or retirement income | | | |
| Interest; dividends; royalties; income from rental properties, | | | |
| estates, and trusts; alimony; child support; assistance from | | | |
| outside the household; and other miscellaneous sources | | | |
| Total Income per Year | | | |
| | | | |
| certify that the family size and income information above is c Patient or Guarantor Name (print): | orrect: | | |
| | orrect: | Date: | |
| | orrect: | Date: | |
| Patient or Guarantor Name (print): | | Date: | |
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Verification and Set Up Check List

| Identification/Address | Source / Completed by | Date |
|---|-----------------------|------|
| Identification/Address: Driver's license, utility | | |
| bill, employment ID, or other | | |
| Income: Prior year tax return, three most recent | | |
| pay stubs, or other | | |
| Decision Letter Sent | | |
| | | |
| Patient Account Set up in Practice Management | | |
| system | | |