



PATHS
Live Life. Be Healthy.

Community
Medical Center

SLIDING FEE SCALE APPLICATION

If you have insurance and do not wish to apply for the sliding fee scale please initial here: _____

Patient Name (Printed): _____ Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Do you file taxes? Yes No

How many people are in your household dependent on this income? _____ (include yourself)

Please complete the following:

Name (Spouse): _____ SS# _____ - _____ - _____ Date of Birth ____ / ____ / ____

Name (Child/Dependent): _____ SS# _____ - _____ - _____ Date of Birth ____ / ____ / ____

Name (Child/Dependent): _____ SS# _____ - _____ - _____ Date of Birth ____ / ____ / ____

Name (Child/Dependent): _____ SS# _____ - _____ - _____ Date of Birth ____ / ____ / ____

Name (Child/Dependent): _____ SS# _____ - _____ - _____ Date of Birth ____ / ____ / ____

Name (Child/Dependent): _____ SS# _____ - _____ - _____ Date of Birth ____ / ____ / ____

How often do you get paid? Weekly Bi-Weekly Monthly Annually Does not apply

Please list your net income for everyone in your household:

Salary Wages:	\$ _____	Social Security:	\$ _____
Interest on Savings Accounts:	\$ _____	Dividends on Investments:	\$ _____
Pension:	\$ _____	Personal Business Profits:	\$ _____
Rental Income:	\$ _____	Disability:	\$ _____
Unemployment:	\$ _____	Alimony:	\$ _____
Veteran's Benefits:	\$ _____	Child Support:	\$ _____
Aid to Dependent Children:	\$ _____	SSI:	\$ _____
Other: _____	\$ _____	Other: _____	\$ _____

Total Annual Income: \$ _____

The information provided concerning the size of my family and my family's net annual income from all sources is true, accurate, and complete to the best of my knowledge. I realize that PATHS Community Medical/Dental Center will rely on such information to determine how much my account will be discounted. I realize that knowingly giving false information in this case may result in criminal prosecution under the laws of Virginia. I agree to report any change in either my income or my family size to PATHS. I know that the information I have given will continue to be relied upon until it is changed. PATHS may initiate a review of my payment status at any time to verify the information I have provided.

Signature: _____ Date: ____ / ____ / ____

For Front Desk Use Only: Sliding Fee Scale Expiration Date: ____ / ____ / ____ Initial: _____