MOUNTAIN LAUREL MEDICAL CENTER

Sliding Fee Application
Confidential Patient Income Information

Patient Name: _____ DOB: _____

(Name) Head of Household: _____ Date: _____

Address: _____
City *State* *Zip*

Phone: _____

Employer: _____ Marital Status: _____

Is Your Spouse Employed? _____ Spouse's Employer _____

Please list self, spouse and any dependents under the age of 18

NAME	AGE	EMPLOYED YES	EMPLOYED NO	GROSS INCOME*	PER WEEK MONTH OR YEAR

*** PLEASE SUBMIT THE LAST TWO PAY STUBS AND/OR PROOF OF ANY INCOME SUCH AS SOCIAL SECURITY, VETERANS BENEFITS, AND WORKERS ' COMPENSATION, PUBLIC ASSISTANCE AND/OR UNEMPLOYMENT BENEFITS FOR ALL HOUSEHOLD MEMEBERS. IF YOU ARE SELF EMPLOYED SUBMIT YOUR MOST RECENT YEAR'S TAX RETURN.**

Are you or any member of your household self-employed? YES _____ NO _____

If yes, please specify type of business and income after expenses *AND* submit a copy of last year's1040 Tax Return:

Business: _____ Income: _____

PLEASE COMPLETE BACK OF FORM

PLEASE LIST OTHER SOURCES OF INCOME:

SOURCE	YES	NO	AMOUNT	PER WEEK, MONTH OR YEAR
Unemployment Compensation				
Social Security				
Disability Benefits				
Worker's Compensation				
Veterans Benefits				
Alimony				
Child Support				
Pension				
Interest				
Dividends				
Rental Income				
Estate/Trusts				
Other:				

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND ALL SOURCES OF INCOME REQUIRED HAVE BEEN REPORTED. I FURTHER UNDERSTAND THAT I NEED TO REPORT ANY INCOME CHANGES AS THEY OCCUR TO THE MOUNTAIN LAUREL MEDICAL CENTER STAFF.

SIGNED: DATE:

APPROVED BY: EXPIRATION DATE: