CONFIDENTIAL

SOUTHERN REGION COMMUNITY HEALTH CENTER

"SLIDING FEE SCALE APPLICATION"

SECTION A - Applicant Information:

NAME:______________________________ DATE OF BIRTH: ___/___/___

SPOUSE'S NAME:______________________________ DATE OF BIRTH: ___/___/___

PERMANENT MAILING ADDRESS:______________________________

____

MARITAL STATUS: SINGLE____ MARRIED____ WIDOWED____ DIVORCE/SEPARATED____ C/L____

SECTION B - Family Financial Status:

	APPLICANT	SPOUSE
OCCUPATION:		
EMPLOYER:		
ANNUAL GROSS SALARY:	$	$

OTHER SOURCES OF INCOME:
(FOR APPLICANT, SPOUSE, AND DEPENDENT FAMILY MEMBERS)

SOURCE	TOTAL AMOUNT
STATE SUPPLEMENTARY PAYMENTS	$
RETIREMENT, DISABILITY, WORKERS COMPENSATION, SOCIAL SECURITY, UNEMPLOYMENT COMPENSATION.	$
ALIMONY, CHILD SUPPORT	$
DIVIDENDS, INTEREST, GIFT, INHERITANCE	$
TOTAL SALARY AND OTHER SOURCES OF INCOME:	$

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