Corporate Office
1600 East 32nd Street - Silver City, NM 88061
575-538-2981 Toll Free 866-538-2981 Fax 575-388-3373
www.silverhealthcare.org

SLIDING FEE DISCOUNT APPLICATION

It is the policy of Silver Health CARE, PC 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 (with applicable documentation) to Silver Health CARE any Wednesday between 9:00 AM and 11:00 AM to determine if you or members of your family are eligible for a discount.

All additional requested documentation must be submitted within two weeks of receipt of application or this application will no longer be considered valid and patient will be responsible for all charges for services received during this period of time.

The discount will apply to all services received at Silver Health CARE, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services.

This form must be completed every 6 months or if your financial situation changes.

Name of Head of Household			**Place of Employment**	
Mailing Address	**City**	**State**	**Zip**	**Phone**

Please list spouse and dependents under age 18:

Name	**Date of Birth**	**Name**	**Date of Birth**
Self		**Spouse**	
Dependent		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	

Annual Household Income:

Source	Self	Spouse	Other	Total
Gross Wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensations, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' 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 birth certificate, Social Security card, driver's license, prior year's tax returns, three most recent months of pay stubs, and/or other information verifying income **will be required** before a discount is approved. Failure to provide all requested income documentation will result in cancellation of discount.

I certify that the family size and income information shown above is complete and correct. I have also provided all requested documentation listed below.

Name (Print): _____ Date: _____

Signature: _____

Office Use Only

Date Received: _____ Received By: _____

Comments: _____

_____

Date Approved: _____ Approved By: _____

Approved Discount: _____ Effective Date: _____

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, utility bill, employment ID, Social Security card, or other		
Income: Prior year's tax return, three most recent months of pay stubs, or other		
Insurance: Insurance cards		
Medicaid: Application made or evidence of rejection		
Other Information (Specify):	**Deadline Date**	**Billing Initials**