



Sliding Fee Eligibility Form

Glendale Area Medical Center
850 Main Street PO Box 375
Coalport, PA 16627

As an FQHC we are required to report all financial information to keep your affordable, quality health care!

Patient Name: _____ Date of Birth: _____

Refused Sliding Fee Scale _____ (Patient's Initials)

Instructions: Please complete entire form. Proof of Income is required and this form must be updated every year. Acceptable Proof of Income include a pay stub, tax return, Unemployment/Social Security/Disability award letters, etc. Please confirm with a staff member for other acceptable forms of proof of income.

Name of Applicant: _____

Address: _____

City, State, Zip: _____

Last Date Worked of Principal Wage Earner: _____ (month/year)

Is Spouse Employed? _____ **# of Family Residing with You:** _____

GROSS MONTHLY INCOME: \$ _____

Before taxes. If married, joint income total...

WELFARE ASSISTANCE: \$ _____

Cash and food stamp total...

ALIMONY/CHILD SUPPORT: \$ _____

WORKERS COMPENSATION BENEFITS: \$ _____

ALLOWANCE FROM FAMILY/FRIENDS: \$ _____

OTHER: \$ _____

TOTAL: \$ _____
(Add all amounts listed above)

I hereby declare that the above information is true to the best of my knowledge.

Signature: _____ **Date:** _____

(Signature required by patient/guarantor)

Office use only - Staff Initials: _____ Sliding Fee Discount _____ %
Sliding Fee Effective Date: _____ Sliding Fee Expiration Date: _____