RURAL HEALTH SERVICES, INC.

SLIDING FEE SCALE APPLICATION

☐

Clyburn Center for Primary Care
1000 Clyburn Place, Aiken, SC 29801
803-380-7000

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Margaret J. Weston Community Health
4645 August Road, Beech Island, SC 29842
803-380-7000

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Family Health Care
120 Darlington Drive, Aiken, SC 29803
803-380-7000

SLIDING FEE DISCOUNT APPLICATION

It is the policy of **Rural Health Services, Inc. (RHS)**, 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 it to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at RHS, **but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services.** This form must be completed every 12 months or if your financial situation changes.

HEAD OF HOUSEHOLD INFORMATION

Head of Household: ______ **Place of Employment:** ______

Home Phone: ___ - ___ - ___ **Cell Phone :** ___ - ___ - ___ **Other :** ______

Email : ______

Address : ______ **City:** ______ **State:** ______ **Zip:** ______

PLEASE LIST SPOUSE, DEPENDENTS UNDER AGE 18 AND OTHER HOUSEHOLD MEMBERS.

	Name	DOB		Name	DOB
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		
Household Member			Household Member		

ANNUAL HOUSEHOLD INCOME

Income Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income.				
Interest, dividends, rent royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
Total Income				
Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.				

I certify that the family size and income information shown above is correct.

Print Name of Patient: ____________________

Signature of Patient: ____________________ **Date:** ____________