Good Samaritan Family Health Center

Sliding Fee Discount Application

Patient Information:

Name: ______________________________________ Date of Birth: __________________

Household Information: List ***all*** individuals living in the home.

Name Date of Birth

1) ____
2) ____
3) ____
4) ____
5) ____

Income Information: Please complete for all adult household members who are employed. Proof of income (income tax return or last 2 paystubs) ***must*** be provided.

Employed person: _____________________ Type of income: _____________________

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Employed person: _____________________ Type of income: _____________________

Other Income:
Alimony $___________ Child support $___________ Disability $___________

Pension $____________ Social security $ ___________ Unemployment $___________

By signing below, I agree to provide GSFHC with proof of income and household size for the purpose of calculating my discount. I understand I will be asked to reapply on an annual basis and agree to inform GSFHC if there are changes to my income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of service. I understand that if I fail to submit proof of family size and income, I will be responsible for the full amount of charges. I hereby certify that the information provided is correct.

Applicant signature ______________________________________ Date: __________________

For Office Use Only
MRN # ________________ Effective date _____________Total income $_____________
Discount _________________ Staff initials _______________ 02/2021