YOUR LIFE – YOUR HEALTH OUR CONCERN

H.O.P.E. REGIONAL MEDICAL CLINIC
Health | Occupations | Partnerships | Education

Sliding Fee Discount Program Application

To apply for discounted service your family and income information are required.

If you have any questions, please contact us at (252) 517-9090.

Applicant Information

Patient Name: _____

Date of Birth: _____

If patient is under 18, Parent/Legal Guardian and Relationship:

_____

Do you have medical insurance? Yes _____ No _____

Are you prepared to pay for your visit today? Yes _____ No _____

Are you employed? Yes _____ No _____

Household Information

Please list all members of your household. Include those who contribute to the household income and persons you claim on your taxes.

How many people are in your family? #Children _____ #Adults _____ = Total _____

Name	Age	Relationship to Patient

Income Information

Give an estimate of your household Income

My household earns $_____

Please select the frequency of earnings: Weekly _____ Biweekly _____ Monthly _____ Yearly_____

Please check which item(s) you will be providing as proof of income.

- (3) Most recent check stubs _____

  (No older than 60 days)

- W-2, 1099 Form _____

  (previous year)

- Benefit statement/letter _____

  (Most recent year. Ex: Disability, unemployment, VA statements)

Note: If you are unable to provide one of the above proofs of income, we will be unable to process your application.

Certification

I hereby declare that the information provided is true and correct. I also understand that any willful dishonesty may render for refusal of this application.

Signature_____ Date_____

Return Process

Your application may be mailed into the office or maybe dropped off in person to the following address.

H.O.P.E. Regional Medical Clinic

546 West Ridgeway St.

Warrenton, NC 27589

Office Use Only

Approve_____ Denied_____

Application processed by: _____

Date: _____