STAFF USE ONLY

CHART #	

DISCOUNTED/ SLIDING FEE AND
FAMILY ASSISTANCE PLAN APPLICATION

It is Families Together of Orange County's policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return 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 the center but not those services which are purchased from outside, such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed annually and/or if there are any changes. Please inquire at the front desk if you have questions.

HEAD OF HOUSEHOLD INFORMATION			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	
NUMBER OF DEPENDENT PERSONS LIVING IN YOUR HOUSEHOLD:			
HEALTH INSURANCE PLAN:		SS #:	
ADDRESS:	CITY:	STATE:	ZIP:
CELL PHONE#:	HOME PHONE#:	EMAIL:	
EMPLOYER:	OCCUPATION:	WORK PHONE#:	

PLEASE LIST SELF, SPOUSE AND DEPENDENTS UNDER THE AGE OF 18		
	NAME	**DATE OF BIRTH**
SELF		
SPOUSE		
DEPENT # 1		
DEPENT # 2		
DEPENT # 3		
DEPENT # 4		
DEPENT # 5		
DEPENT # 6		

INCOME INFORMATION				
SOURCE	**SELF:**	**SPOUSE:**	**OTHER:**	**TOTAL:**
Gross wages, salaries, tips, etc.				
Social Security, Pension, annuity, and veteran's benefits				
Income from Alimony, child support, military family allotments				
Income from business, self employment, and dependents				
Income from Rent, interest, dividend, and other income				
TOTAL INCOME:				

Note: Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

VERIFICATION CHECKLIST (Attach copies)	YES	NO
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security Card, or other		
Income: Prior year tax return, most recent pay stubs, or other		

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

NAME (Print): _____ SIGNATURE: _____ DATE: _____

OFFICE USE ONLY	
PATIENT NAME:	DISCOUNT:
DATE OF SERVICE:	APPROVED BY: