

McKinney Community Health Center, Inc.

218 Quarterman Street
Waycross, Georgia 31501

Main Office
(912) 287-0301

Medical
(912) 287-9140

SLIDING FEE APPLICATION

Revised 4/18/07

APPLICANT'S NAME AND ADDRESS				
Last Name	First Name	Middle Initial	Social Security No.	
Present Address	Street	City	State	Zip Code
Permanent Address	Street	City	State	Zip Code
Telephone Number	Mobile Phone Number	Email Address		
HOUSEHOLD INCOME				
Total Income	Frequency of Income	Source of Income		
FAMILY MEMBERS				
Please list all family members including yourself below. List additional family members on back of this form.				
Last Name	First Name	Middle Initial	Date of Birth	Social Security No.
Last Name	First Name	Middle Initial	Date of Birth	Social Security No.
Last Name	First Name	Middle Initial	Date of Birth	Social Security No.
Last Name	First Name	Middle Initial	Date of Birth	Social Security No.
Total Number in Family _____				
ATTESTATION				
I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform McKinney Community Health Center, Inc. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of McKinney Community Health Center, Inc. I hereby acknowledge that I read the foregoing disclosure and understand it.				
Signature of Applicant _____			Date _____	
MCHC Witness _____			Date _____	

A. Proof of Identification (choose (1) form of ID)

1. Driver's License
2. Valid Government ID
3. Current Utility Bill / Telephone Bill
4. Social Security and/or Birth Certificate for each dependent

B. Proof of Income (choose one (1) form of income)

1. Recent Federal Income Tax Return
2. Recent Pay Stubs for one month

C. Proof of NO income

(choose applicable verification)

1. Notarized Statement from person(s) who provide your financial support verifying you are not employed
3. Statement from Social Security Admin stating you do or do not receive benefits
4. Statement from Dept. of Family and Children Services stating you do or do not receive benefits
5. Letter from public facility verifying residency and/or income.

If section B is not applicable go to C

FOR OFFICIAL USE ONLY			
<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved	Percentage _____	Eligibility Date _____
Official Signature _____		Renewal Date _____	

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