



Sliding Fee Application

Name _____ DOB ____/____/____ Chart Number _____
Month Day Year

The sliding fee program is offered to our patients in order to help them pay their bill, regardless if they have insurance or not. If you would like to fill out the information below we will be happy to tell you if you qualify for this program.

Please list all family members that live in your household that you are responsible for paying their bills or medical care.

Name _____ Relationship _____ Date of Birth ____/____/____

Number of people employed in your house? _____

Employer _____ Pay status () Weekly () Biweekly () Monthly
Rate of Pay _____

Employer _____ Pay status () Weekly () Biweekly () Monthly
Rate of Pay _____

Other monthly income received by you or dependent(s): SSI \$ _____, Child Support \$ _____,
Disability \$ _____, Unemployment \$ _____, Other \$ _____, Other \$ _____.

Do you have any type of private insurance? _____
Goshen Medical Center, Inc. will file your insurance for you. Insurance payments will be applied to patient's total charges before sliding fee adjustment. Patients will be refunded any amount exceeding total charges.

Do you have any economic burdens (medical or otherwise) which you feel affects your ability to meet your obligations? _____

I hereby certify that the foregoing statements are true and correct as furnished to GMC, Inc. for the purpose of discount adjustments to my account. I understand falsification of information may nullify any discounts given. I hereby authorize Goshen Medical Center, Inc. to contact persons/employers named on this application for verification purposes.

Applicant Signature _____ Date ____/____/____
GMC, Inc Staff _____ Date ____/____/____
GMC, Inc Staff _____ Date ____/____/____

I chose to decline the sliding fee application. _____
Patient Signature/Parent or Guardian if minor Date ____/____/____