Texas A&M Primary Care & Population Health
Patient Sliding Fee Discount Application

Patient Information			**Today's Date:** / /	
First Name:	**Middle:**	**Last:**	**Other Names:**	
Home Address:		**City:**	**State:**	**Zip:**
Mailing Address:		**City:**	**State:**	**Zip:**
Home Phone#:	**Mobile Phone#:**			
Date of Birth:	**Social Security#:**	**Do you have insurance?**	**Yes**	**No**

Marital Status: Single In a relationship Married Divorced
Separated Widowed

Household Size		
Name	**Date of Birth**	**Relationship**
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Note: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax returns, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual household income and your family size will be used to calculate your discount.

Sliding Fee Scale:
A – 100% Discount
B – 80% Discount
C – 60% Discount
D – 40% Discount
E – 20% Discount
F – 0% Discount

Household Income			
Name	**Amount**	**Frequency (circle one)**	**Employer:**
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
Total:	$	Weekly Monthly Yearly	

Internal Use Only: Date _____ Reviewed by: _____ Approved SFS Level: _____
Reason disapproved: _____