HAWC SLIDING FEE APPLICATION FORM

TEL: (775) 329-6300

FAX: (775) 323-3140

PATIENT NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER:
CURRENT PHYSICAL ADDRESS:	
CURRENT MAILING ADDRESS:	

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

( ) MEDICAID ( ) PRIVATE INSURANCE NAME OF INSURANCE:

( ) MEDICARE

NAME OF PERSON RESPONSIBLE FOR THE BILL:

NAME OF DEPENDENTS	DOB	NAME OF DEPENDENTS	DOB

PLEASE CHECK TYPE OF INCOME YOU ARE RECEIVING:	AMOUNT	ANNUAL
( ) MONTHLY EMPLOYMENT WAGES		
( ) MONTHLY SOCIAL SECURITY BENEFIT		
( ) WEEKLY UNEMPLOYMENT BENEFIT		
( ) MONTHLY DISABILITY BENEFIT		
( ) MONTHLY ALIMONY/CHILD SUPPORT		
( ) MONTHLY PENSION		
( ) OTHER:		
TOTAL:		

SIGNATURE:	DATE:

FOR OFFICE USE ONLY

TYPE OF ID:	QUALIFIED FOR:	MEDICAL	DENTAL
PROOF OF ADDRESS:		( ) MINIMUM (B)	( ) 60% (D)
# OF HOUSEHOLD MEMBERS:		( ) 25% (C)	( ) 75% (E)
ANNUAL INCOME:		( ) 50% (D)	( ) 100% (F)
( ) PENDING		( ) 75% (E)	
FOLLOW-UP APT:		( ) 100% (F)	

STAFF SIGNATURE:	DATE:

7/13/2006