Pediatric
Associates
PROF LLC

LIST ALL sources of GROSS MONTHLY INCOME for the household:

	Amount
Employment (including tips)	________________
Unemployment Compensation	________________
AFDC	________________
Food Stamps	________________
Child Support	________________
Pension	________________
Social Security	________________
Other	________________
TOTAL GROSS MONTHLY INCOME	===============

If any information you have given is found to be false, you will be denied future Discounts at Pediatric Associates. Please be prepared to provide proof of income.

____
Signature   Date

==
DO NOT WRITE BELOW THIS LINE
==

Total number in household _______   Total household yearly income __________

Fee Category % _________ Discount

Please provide the one following documents:

____ Pay Stub (2 most recent) _____ Tax Return (current year) _____ Bank Statement

____ Other (proof of other income)

Approved by: ____

CONFIDENTIAL INCOME AND INSURANCE STATEMENT

Patient Name ____ Date ____________

Have you applied for Medicaid? Yes No Date ____________

Results ____

PLEASE CHECK any circumstances listed that cause you to seek financial assistance at Pediatric Associates:

_____ I am not eligible for Medicaid or any other government assisted programs.

_____ I cannot afford private health insurance.

_____ My employer does not offer health insurance benefits.

_____ The patient is not covered by an employed family member's health insurance.

_____ Other

LIST ALL members of the household, starting with the PATIENT:

	Name	Relationship to Pt.	Age	Employer	Full or Part Time
1.					
2.					
3.					
4.					
5.					
6.					
7.					