Pediatric
Associates
PROF LLC

LIST ALL sources of GROSS MONTHLY INCOME for the household:

	Amount
Employment (including tips)	________________
Unemployment Compensation	________________
AFDC	________________
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: ____

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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.____