C. L. Brumback Primary Care Clinics
Health Care District Palm Beach County

Sliding Fee Scale Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in strict confidence. If approved, eligibility will expire in 12 months and you will need to re- apply. Based on the Federal Poverty Guidelines, your total household annual income will be used to calculate the level of your payment.

Patient Information

First Name: _____ **Last Name:** _____ **Date of Birth:** ____/____/_____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** (_____)_____ **Chart Number:** _____

Household Information and Income

What is your marital status? ☐ **Single** ☐ **Married** ☐ **Widow(er)** ☐ **Separated** ☐ **Divorced**

Do you own or rent your home? ☐ **Own** ☐ **Rent** ☐ **Live with Someone**

Amount of household income (monthly):

You	Your Spouse	Your Children	Other Household Members	Total Household Income

Sources of Income:

Source of Income	You	Your Spouse	Your Children	Other Members	Total from Source
Employment/Contract work					
Unemployment					
Social Security					
Public Assistance					
Retirement Pension					
Stock or Certificates					
Rental Income					
Interest Income					
Child Support, Alimony					
Veteran income					
Worker's Compensation					
Other (Specify)					

Do you have any type of insurance that will cover all or part of your medical expense? **If yes, please add name of insurance and member ID:**	**Name of Insurance:**	**Member ID:**

All Individuals Living in Household			
Name and Date of Birth:	**Phone Number:**	**Name and Date of Birth:**	**Phone Number:**
		Total Number of People in Household:	

I declare the above information is true and have given the CL Brumback Primary Care Clinic permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Patient/Guardian Signature: _____

Patient/Guardian Printed Name: _____

Date: _____/_____/_____

* Please note that this information will undergo an audit process to ensure accuracy and to ensure this is allowable by your insurance, if you have any. We will reach out to you if we have any questions or if you are not eligible.