McKinney Medical Center, Inc.
218 Quarterman Street
Waycross, GA 31501

Name:
Address:
City, State:
Zip Code:
Telephone:
Cell Number:
Email Address:
Social Security #:
Date of Birth:

Sliding Fee Eligibility Form

Required Documentation every 6 months

A. Proof of Identification
(Must have 2 of listed ID below for the person applying and 1 for any other member listed in household)

1. Picture ID
2. Social Security Card
3. Birth Certificate
4. Current bill

B. Proof of Income (Current Month)For every person over age 18

1. Federal tax return(1040Forms)
2. Month's paystubs/social security benefit letter/retirement benefit letter.
3. **Notarized** wage statement from Employer

C. Proof of NO Income

1. GA Dept of Labor Wage Determination Letter
2. **Notarized** statement from person providing your financial support

Today'sDate: ☐

Number of people living in your home? ☐

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

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

Amount of income? _____

Place of Employment? _____

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below ☐ No ☐

_____

Please provide a copy of identification for all household members

Name:	Date of Birth:	Social Security Number:

I declare the above information is true and have given the McKinney Medical Center, Inc. permission to investigate any information given in this application. I understand 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.

Signature:	Date:	***Clinic Purpose Only*** Income Code:

For Official Use Only	
☐ Approved	☐ Rejected
Eligibility Date:	Renewal Date:

Revised 11/20/2018