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 12 months

A. Proof of Identification
(Must have any 2 ID's for EVERY member listed in household examples of)

1. Picture ID
2. Social Security Card
3. Birth Certificate
4. Current bill with name and address

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 ☐

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	ACCOUNT NUMBER (OFFICE USE ONLY)

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:

Office Use only:

Approval Date_____ Slide:_____

Renewal Date_____ Pat. Rep Initials_____

Revised 12/23/2019