HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway Street
Johnsonville, SC 29555
843-386-3573 Fax: 843-386-2617

1608 N. Main Street
Conway, SC 29526
843-248-4700 Fax: 843-488-6345

145 Palmetto Pointe Drive
Marion, SC 29571
843-423-2400 Fax: 843-423-2070

SLIDING FEE APPLICATION

Account #:____________________

LAST NAME: ____________________ FIRST NAME: ____________________ DOB:____________________

MAILING ADDRESS: ______________________________ ______________ ____________ ____________

Street City State Zip

MARITAL STATUS (click one) MARRIED SINGLE SEPARATED DIVORCED WIDOWED

SOCIAL SECURITY #:____ PHONE #:________________________________

HOW DID YOU HEAR ABOUT US?____

FARM WORKER? ☐Yes ☐No MIGRANT WORKER? ☐Yes ☐No FULL/PART TIME JOB?________________

WORK PHONE #:__________________________________ EMPLOYER NAME: ________________________________

WORK ADDRESS:____

Street City State Zip

	PERSONS LIVING IN HOUSE	RELATIONSHIP	AGE
1.			
2.			
3.			
4.			
5.			
6.			

INCOME:

Head of Household				Spouse				Other			
Source of Income: (click on frequency below)				**Source of Income:** (click on frequency below)				**Source of Income:** (click on frequency below)			
Weekly	**Bi-Wkly**	**Monthly**	**Bi-Monthly**	**Weekly**	**Bi-Wkly**	**Monthly**	**Bi-Monthly**	**Weekly**	**Bi-Wkly**	**Monthly**	**Bi-Monthly**
Earning		$		Earning		$		Earning		$	
Social Security		$		Social Security		$		Social Security		$	
Disability		$		Disability		$		Disability		$	
Retirement		$		Retirement		$		Retirement		$	
Worker's Comp		$		Worker's Comp		$		Worker's Comp		$	
Unemployment		$		Unemployment		$		Unemployment		$	
Support		$		Support		$		Support		$	
EBT		$		EBT		$		EBT		$	
Weekly Total		$		Weekly Total		$		Weekly Total		$	
Monthly Total		$		Monthly Total		$		Monthly Total		$	
Yearly Total		$		Yearly Total		$		Yearly Total		$	

SF LEVEL:______________________

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE PERMISSION TO HEALTH CARE PARTNERS OF SC TO VERIFY ALL THE ABOVE INFORMATION. IF I HAVE A CHANGE IN FINANCIAL STATUS, I WILL NOTIFY THE RECEPTIONISTS. I AGREE TO BRING THE DOCUMENTATION NEEDED FOR DISCOUNT BY ______________________________. IF I FAIL TO DO SO, I WILL BE RESPONSIBLE FOR THE FULL CHARGES.

APPLICANT SIGNATURE:____ DATE:__________________________

HCPSC REPRESENTATIVE SIGNATURE:____________________________________ DATE:__________________________

ADD-ON APPLICATION:

NAME:____ DOB:______________________

MAILING ADDRESS:____

Street City State Zip

MARITAL STATUS (click one) MARRIED SINGLE SEPARATED DIVORCED WIDOWED

SOCIAL SECURITY #:_______________________________________PHONE #:__________________________________

HOW DID YOU HEAR ABOUT US?____

RELATIONSHIP TO MAIN ACCOUNT HOLDER:____

INCOME:

INDIVIDUAL			
Source of Income: (click on frequency below)			
Weekly	**Bi-Wkly**	**Monthly**	**Bi-Monthly**
Earning		$	
Social Security		$	
Disability		$	
Retirement		$	
Worker's Comp		$	
Unemployment		$	
Support		$	
EBT		$	
Weekly Total		$	
Monthly Total		$	
Yearly Total		$	

SF LEVEL:______________________

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE PERMISSION TO HEALTH CARE PARTNERS OF SC TO VERIFY ALL THE ABOVE INFORMATION. IF I HAVE A CHANGE IN FINANCIAL STATUS, I WILL NOTIFY THE RECEPTIONISTS. I AGREE TO BRING THE DOCUMENTATION NEEDED FOR DISCOUNT BY ______________________________. IF I FAIL TO DO SO, I WILL BE RESPONSIBLE FOR THE FULL CHARGES.

APPLICANT SIGNATURE:____ DATE:___________________________

HCPSC REPRESENTATIVE SIGNATURE:__________________________________ DATE:___________________________