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 #:____________

NAME:______________________________ DOB:______________

MAILING ADDRESS:____
Street City St. Zip

MARITAL STATUS (circle 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 St. Zip

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

INCOME:

Head of Household		Spouse		Other	
Source of Income: (circle frequency below)		Source of Income: (circle frequency below)		Source of Income: (circle 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.

APPLICANT SIGNATURE:______________________________ DATE:______________

HCPSC REPRESENTATIVE SIGNATURE:______________________________ DATE:______________

ADD-ON APPLICATION:

NAME:______________________________ DOB:______________

MAILING ADDRESS:____
Street City St. Zip

MARITAL STATUS (circle 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: (circle 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:______________