HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway Street
Johnsonville, SC 29555
843-386-3573 Fax: 877-322-0181

1608 N. Main Street
Conway, SC 29526
843-248-4700 Fax: 877-322-0181

145 Palmetto Pointe Drive
Marion, SC 29571
843-423-2400 Fax: 877-322-0181

243 Singleton Ridge Road
Conway, SC 29526
843-248-4700 Fax: 877-322-0181

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	Annually	Weekly	Bi-Wkly	Monthly	Annually	Weekly	Bi-Wkly	Monthly	Annually
Gross Earning		$		Gross Earning		$		Gross Earning		$	
Social Security		$		Social Security		$		Social Security		$	
Disability/*WC		$		Disability/*WC		$		Disability/*WC		$	
Retirement		$		Retirement		$		Retirement		$	
Self-Employment		$		Self-Employment		$		Self-Employment		$	
Unemployment		$		Unemployment		$		Unemployment		$	
Support		$		Support		$		Support		$	
Weekly Total		$		Weekly Total		$		Weekly Total		$	
Monthly Total		$		Monthly Total		$		Monthly Total		$	
Yearly Total		$		Yearly Total		$		Yearly Total		$	

***Worker's Comp**

SF LEVEL:_____ Annual Total_____ EHR Total_____

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:_____

HCP 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?_____

Is the applicant interested in applying for insurance through ACA? Yes____ N0 ____

RELATIONSHIP TO MAIN ACCOUNT HOLDER:_____

INCOME:

INDIVIDUAL			
Source of Income: (circle frequency below)			
Weekly	**Bi-Wkly**	**Monthly**	**Annually**
Gross Earning		$	
Social Security		$	
Disability/*WC		$	
Retirement		$	
Self-Employment		$	
Unemployment		$	
Support		$	
Weekly Total		$	
Monthly Total		$	
Yearly Total		$	

***Worker's Comp**

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:_____

Clinical Office: 1608 N. Main St. * Conway, SC 29526 * Main: 843-248-4700 * Fax: 843-488-6345 * www.hcpsc.org