



HEALTH CARE PARTNERS OF SC, INC.

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

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

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

145 Palmetto Pointe Rd.
 Marion, SC 29571
 843-423-2400
 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? _____

RELATIONSHIP TO MAIN ACCOUNT HOLDER: _____

INCOME:

INDIVIDUAL			
Source of Income:			
<small>(circle frequency below)</small>			
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: _____

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APPLICANT SIGNATURE: _____

DATE: _____

HCPCS REPRESENTATIVE SIGNATURE: _____

DATE: _____