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 (*for office use only*):

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:________________________

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ADD-ON 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?____

IS THE APPLICANT INTERESTED IN APPLYING FOR INSURANCE THROUGH OBAMACARE (ACA)? YES ______ NO ______

RELATIONSHIP TO MAIN ACCOUNT HOLDER:____

INCOME *(for office use only)*:

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	$

SF LEVEL: ____________________

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APPLICANT SIGNATURE:____ DATE:__________________________

HCPSC REPRESENTATIVE SIGNATURE:___________________________________ DATE:__________________________