



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

6874 Hwy 908
 Gresham, SC 29546
 843-352-8772
 Fax: 877-322-0181

1606 B Main St.
 Conway, SC 29526
 843-488-6350
 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

	FAMILY SIZE (Self and Dependents)	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: _____

HCPCSC REPRESENTATIVE SIGNATURE: _____

DATE: _____