HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-248-4700
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
843-248-4700
Fax: 877-322-0181

6874 Hwy 908
Gresham, SC 29546
843-248-4700
Fax: 877-322-0181

1606 B Main St.
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

	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:_____

HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-248-4700
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
843-248-4700
Fax: 877-322-0181

6874 Hwy 908
Gresham, SC 29546
843-248-4700
Fax: 877-322-0181

1606 B Main St.
Conway, SC 29526
843-248-4700
Fax: 877-322-0181

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: _____

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:_____

HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-248-4700
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
843-248-4700
Fax: 877-322-0181

6874 Hwy 908
Gresham, SC 29546
843-248-4700
Fax: 877-322-0181

1606 B Main St.
Conway, SC 29526
843-248-4700
Fax: 877-322-0181

INFORMATION REQUESTED FOR SLIDING FEE

PROOF OF INCOME:

Proof of Income is defined as gross annual earnings (i.e., before taxes) for all members of the family from all sources including salaries, unemployment, social security, disability benefits, as well as alimony, retirement, interest and/or dividend income, self-employment income, self-declaration income, support from others as well as other earned income or taxable income per IRS tax form 1040.

Patient or head of household must provide:

- Two most recent pay stubs (even if paid bi-weekly or monthly).
  - **If paid in cash only, then:**
    - Letter statement of gross income for each pay period and/or weekly hours and hourly pay from employer. Must include the name of the employer (or business) with address, phone number and signature of owner.
- The last tax return, form 1040
- Social security/updated disability statement within the last 12 months.
- Retirement statement.
- Updated alimony or support statement.
- Unemployment statement.
- Temporary Assistance for Needy Families (TANF)
- Workers' compensation.
  - No income but receiving support for living expenses:
    - Signed statement with the date, name, address, phone number including the amount of support you receive for the service you provide.
- Other sources of income, such as rental annuities, or other forms of proof of income.

FAMILY SIZE:

A family is defined as oneself, plus all dependents. The definition of dependent is defined as those individuals receiving more than 50% support from the applicant and only immediate family members are eligible to be claimed as dependents. Immediate family members are persons related by birth, marriage, adoption, parents, grandparents, and guardians (must present legal document). Unrelated individuals, even in the same house, are considered to be separate families. A copy of the Federal Income Tax Return is an example to help identify dependents.

Exceptions to determining Family Size:

Prevention of homelessness: In the event a related (by birth, marriage, or adoption) family member resides, but does not earn any income, and the sole purpose of the family member residing in the house with relatives is to prevent homelessness, their family members will not be counted as family size on the application. In this situation, the family members do not have a shared financial responsibility. The patient would be required to complete Application Attachment/No Source of Income and a Sliding Fee application.

SLIDING FEE APPLICATION EXPIRES IN ONE YEAR!

Should you have any questions or concerns, please contact:
Tatiana Villamizar * 1604A N. Main St., Conway, SC 29526
Email: tatiana.villamizar@hcpsc.org * Direct Line: 843-488-6353

revised 06.24.24