Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Chart Number:

ALABAMA REGIONAL MEDICAL SERVICES
P.O. BOX 11526
BIRMINGHAM, AL 35202

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence You must verify your income annually. Your yearly income tax return with a copy of your W-2 form, payroll check stub (s), or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: _____ Number of people living in your home? _____

What is your marital status? ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

Do you own or rent your home? ☐ Own ☐ Rent ☐ Live with Someone

Amount of Household Income?

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment?

You	Your Spouse	Your Children	Other Person

Do you have money in your savings account? $ _____
Do you have money in a checking account? $ _____

Do you have any rental property? Yes ☐ No ☐
Do you own stock or certificates? Yes ☐ No ☐

Do you receive any income from any source, including the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below ☐ No ☐

Give Names, DOB, and SSN of all individuals living in the household.

Name:	Date of Birth:	Social Security Number:

I declare the above information is true and have given Alabama Regional Medical Services permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that providing false information may disqualify me from receiving a discount and may jeopardize my status at ARMS and/or be punishable by law. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature:	Date:	*Clinic Purpose Only* Income Code:

ARMS Staff Verification Signature _____ Date _____

Revised 7/3/2019