



**Family Assistance Plan Application**

It is the policy of South Alamo Medical Group to provide essential services regardless of the patients ability to pay. Discount are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Name of Head of Household			Place of Employment		
Address	City	State	Zip	Phone	
Health Insurance Plan			Social Security Number		

**Please list spouse and dependents under age 18**

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Employee Initials: \_\_\_\_\_

Date: \_\_\_\_\_



**Annual Household Income**

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc...				
Social Security, pension, annuity, and veterans benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				

<b>Verification Checklist (attach copies)</b>	Yes	No
Identification/Address: Drivers License, birth certificate, employment ID, social security card, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Card(s)		
Medicaid: Application made or evidence of rejection.		

I certify that the information shown above is correct and understand verification is required for approval.

Name: \_\_\_\_\_

Signature: : \_\_\_\_\_

**Office Use Only**

Pay class approved: \_\_\_\_\_ Effective date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Employee Initials: \_\_\_\_\_

Date: \_\_\_\_\_