SOUTH ALAMO MEDICAL GROUP

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: _____

SOUTH ALAMO MEDICAL GROUP

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				

Verification Checklist (attach copies)	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: _____