THE SURGERY CLINIC OF MILAN

4022 Liberty St. Milan, TN 38358
(731) 686-7004, www.surgerymilan.com

APPLICATION FOR SLIDING FEE SCALE

First Name:	Last:	Date of Birth: ____/_____/____
Home Address:		City:
State:	Zip:	
Home Phone:	Cell Phone:	Email:

Household Size	
Number of adults	1 2 3 4 5 6 _____
Number of children under 18	1 2 3 4 5 6 _____

Household Income		
Name	Yearly Amount	SSN:
You	$	
Spouse/Partner	$	
Child	$	
Child	$	
Child	$	
Other	$	
TOTAL	$	

Other income	You	Spouse	Children	Other	Subtotal
Social Security					
SSI					
Retirement Pension					
Social Security					
Child Support, Alimony					

Food Stamps					
Unemployment					
Interest Income					
Family First					
Other income					
				TOTAL:	$

Required Documentation: Proof of Income

- If Employed (Pick One)
  - 1040
  - W-2
  - 2 recent pay stubs
  - Notarized statement from employer

- If Unemployed (Pick One)
  - Public Assistance check stub
  - SSI Check Stub
  - Letter of reference from DHS, Soc Sec.
  - Letter of reference from an organization, or any agency from which you receive benefits.

- Proof of Address (Pick One)
  - Driver's License
  - Other Photo ID
  - Copy of recent address on bill

I hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief.

Name (Print): _____

Signature: _____ Date: _____