It is the policy of Children's Medical Group to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and email it to SFSAPPS@pediatricassociates.com, or return it 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 or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. To maintain your status, this form must be completed every 12 months or whenever your financial situation changes.

Income verification is required. Acceptable forms of verification include the prior year's W-2, two most recent pay stubs, a letter from your employer, or Form 4506-T (if no W-2 is filed). Self-employed individuals must submit details of the most recent three months of income and expenses for their business(s). Patients who are unable to provide income verification in the forms noted above must provide a signed statement of income, and why they are unable to provide independent verification.

By applying to this program, you consent to be contacted by one of our representatives to discuss your application and eligibility via email, phone, or mail.

Name of Parent/Legal Guardian:		**New Patient? YES NO**	
Street Address:	**City:**	**State:**	**Zip Code:**
Phone:	**Patient Name:**		
Name of Primary Care Provider:	**Practice Name:**		

Please list spouse and dependents under the age of 18 years old.

Name:	**Date of Birth**	**Name:**	**Date of Birth:**
Self:		**Dependent:**	
Spouse:		**Dependent:**	
Dependent:		**Dependent:**	
Dependent:		**Dependent:**	

Annual Household Income

Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc	**$**	**$**	**$**	**$**
Income from business, self-employment, and dependents	**$**	**$**	**$**	**$**
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income	**$**	**$**	**$**	**$**
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside household, and other miscellaneous sources	**$**	**$**	**$**	**$**
Total Income:	**$**	**$**	**$**	**$**

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before discount is approved

I certify that the family size and income information shown above is correct.		
Name (Print):	**Signature:**	**Date:**

Official Use Only

Approved Discount:	
Approved By:	
Date Approved:	

Verification Checklist:	**Identification/Address: Driver's License, utility bills, employment ID, or other**	
	Income: Prior year tax return, three most recent pay stubs, or other	
	Insurance: Insurance Cards	