Cornell Scott Hill Health Corporation

Sliding Fee Application

Last name: _____ First Name_____ MI _____

Street: _____ Town/City_____ Zip_____

Home phone _____ Work Phone _____ Cell Phone _____

Social security number _____ Gender ☐ male ☐ female

I am applying for the Cornell Scott-Hill Health Center Sliding Fee Scale program. I have attached the following documents to support my request:

_____ Most recent Federal tax return to support annual income statement

_____ One month's worth of paycheck stubs (4 if paid weekly, 2 if paid bi-weekly)

_____ Assistance support documentation from state sources

_____ A piece of mail addressed to the applicant that has been post-marked within the last 30 days

_____ Other (Specify: support statements from family members, religious or social organizations, etc.) _____

_____

I would like to include other dependent members of my household indicated below for inclusion in this program:

_____ _____
Last Name, First Name, Middle Name *Date of Birth*

_____ _____
Last Name, First Name, Middle Name *Date of Birth*

_____ _____
Last Name, First Name, Middle Name *Date of Birth*

_____ _____
Last Name, First Name, Middle Name *Date of Birth*

_____ _____
Last Name, First Name, Middle Name *Date of Birth*

_____ _____
Last Name, First Name, Middle Name *Date of Birth*

Continue on separate sheet if necessary

Signature _____ Date: _____
Legal Signature *Month day year*

2/7/12