

PLEASE FILL OUT TO APPLY FOR ONE OF OUR PROGRAMS  
FAMILY INCOME DOCUMENTATION WILL BE REQUIRED TO QUALIFY

Family Income Members Legal Names	Relationship to Patient	Date of Birth	Age	Earned Gross Income (Year/Monthly/Biweekly/weekly)
<b>Patient Legal Name:</b>	Self			
<b>Other:</b>				
<b>Other:</b>				
<b>Other:</b>				
<b>Other:</b>				
<b>Other:</b>				
<b>Total Number in Family:</b>	<b>A. Total Gross Income:</b>			<b>\$</b>

Sources of unearned Income	Yes	No	Proof	Amount (Weekly/Biweekly/Monthly/Year)	Total
Alimony					
Child Support					
Supplemental Security Income (SSI)					
AFDC (Aid and Family with dependent children)					
Disability Benefits					
Pension					
Retirement					
Assistance (SNAP, Food Stamps etc.)					
Unemployment					
Second Part-Time Job					
Other Income					
<b>B. Total Unearned Income</b>					<b>\$</b>
<b>Total Annual Family Income from All Sources (A+B)</b>					<b>\$</b>
<b>Tax Form Income</b>					<b>\$</b>
<b>Individually Schedule Business</b>					<b>\$</b>

I hereby certify that to the best of my knowledge that the above information I have provided on this form concerning income living arrangements to be true, accurate, and complete and that I have no income other than that listed above. I promise to notify Little River Medical Center, Inc. at once if there is a change to my income, mailing address or telephone number(s).

I will also notify the Little River Medical Center, Inc. front office if I obtain or have changes to my Medicaid, Medicare insurance or private insurance.

I release my eligibility and health information to pharmaceutical manufactures, or their designee, for the purpose of Institutional Patient Assistance Program (IPAP) audit if I receive eligible pharmaceutical products through one of the Little River Medical Center, Inc.'s pharmacy locations.

SELF PAY, CO-INSURANCE PERCENTAGE OR CO-PAY MUST BE PAID IN FULL AT TIME OF SERVICE

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interoffice Use Only: _____ EIS – Early Intervention Services	_____ TFP – Teen Family Planning
# in Family: _____	Total calculated annual family income: \$ _____
Approved SF: _____	Effective dates approved from _____ Expires _____
Witness (LRMC Staff): _____	Date: _____ Patient Account Number: _____