LRMC | LITTLE RIVER MEDICAL CENTER

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) **In Office Use ONLY**
Patient Legal Name:	Self			
Other:				
Other:				
Other:				
Other:				
Other:				
Total Number in Family:	**A. Total Gross Income:**			**$**

Sources of unearned Income	**Yes**	**No**	**Proof**	Amount (Weekly/Biweekly/Monthly/Year)	Total **In Office Use Only**
Alimony					
Child Support					
Supplemental Security Income (SSI)					
AFDC (Aid A2 Families with Dependent Children)					
Disability Benefits					
Pension					
Retirement					
Assistance (SNAP, Food Stamps etc.)					
Unemployment					
Second Part-Time Job					
Other Income					
				B. Total Unearned Income	**$**
				Total Annual Family Income from All Sources (A+B)	**$**
				Tax Form Income	**$**
				Individually Schedule Business	**$**

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: _______________

Updated: 12/2022