

APPLICATION FOR SLIDING SCALE
THOMAS E. LANGLEY MEDICAL CENTER
1389 S. US HWY 301
SUMTERVILLE, FL 33585
352-793-5900 ext. 2904

Total number of members in household_____

Name	Age	Relationship

Please indicate **ALL** gross monthly income for **everyone** in home:

Wages_____ Child Support_____ Alimony_____

Unemployment_____ Work Comp_____ SSI_____

Self Employment_____ Food Stamps_____

Disability_____ Veteran's/Retirement Pension(s)_____

Total Household Gross Income_____

I hereby certify that the information supplied above is true and correct to the best of my knowledge. I give permission to Thomas E. Langley Medical Center to verify taxes with the IRS through a 4506T form. I am aware that if any information I provide is fraudulent my sliding scale will be terminated.

Signed_____ Date_____

Patient or Guardian

 Financial Counselor

For Administrative Use Only

- 4506 form
- Business Taxes (Schedule C)
- Does slide need to be back dated
- Proper slide in all accts (FFS, Dental, MCR slide)
- Enter Homeless/Double up status
- Update comment screen

_____ The Sliding Scale discount has been explained to me and I understand.