RIVERSIDE PEDIATRICS

FINANCIAL ASSISTANCE APPLICATIONS

Please read the application in its entirety and attach ALL required information that applies to your situation. Incomplete applications may result in delay for the Sliding Fee Discount Program.

Riverside Pediatrics accepts all patients, regardless of their insurance status or ability to pay. We offer the sliding fee scale to all income-eligible uninsured or underinsured patients, based on annual household income, family size, and will not discriminate based on an individual's race, sex, color, national origin, disability, age, sexual orientation, or gender identity. Eligibility for the program is determined by The Federal Poverty Guidelines and updated annually.

If you have been denied other assistance such as South Carolina Medicaid, you may submit the Medicaid Denial Letter with this application. It is not mandatory in order to be eligible for the Sliding Fee Discount Program.

The application requires personal information and proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. The discount will apply to all services rendered at **Riverside Pediatrics ONLY**. This form must be completed every 12 months or if your financial situation changes.

The following information is needed for verification of income:

- Last year's federal tax return (Form 1040). If you did not file last year's taxes, the most current years return must be provided. If, for any reason you do not file taxes, please provide and explanation why.
- Last year's tax federal return for any business that you fully or partly own.
- Statements of wages for the past 8 weeks for all wage earners. These must be back-to-back dates.
- Social Security or Veteran's Administration documentation stating how much you (and/or other family members) receive each month. You should provide the award letter you received when your benefits were issued.
- Statement of wages for anyone in the household receiving unemployment, worker's compensation, pension, retirement, other interest income or any other income yourself and/or the household.
- If you currently do not have any income, please provider a letter of financial support from the person(s) that are currently supporting you.

If you have any questions or need assistance in filling out this application, please contact our Georgetown office at 843-833-8595 or Kingstree office at 843-401-4200.

Once you have completed the forms with the supporting documentation, please return to Riverside Pediatrics front desk, or mail to:

RIVERSIDE PEDIATRICS

ATTN: PRACTICE MANAGER

435 MARINA DRIVE

GEORGETOWN, SC 29440

PH: 843-833-8595

FAX: 843-833-8599

You will be notified of the status of your application within 10 business days of receipt of all income verification requested.

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Section I – Patient Information

Name: _____

Date of Birth: _____

Spouse's Name (if applicable): _____

Date of Birth: _____

Home Phone: _____ Alternate Phone: _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

County of Residence: _____

Preferred Method of Contact: US Mail Email Phone

Sections II-Dependents

Name of Person	Relationship	Date of Birth

Section III - Income

Income includes wages or salary before deductions, unemployment compensation, child support, social security, Veteran's benefits, pension or other retirement income, alimony, gross receipts from self-employment, regular public assistance payments such as AFDC or SSI, worker's compensation, interest income, etc.

* If you do not have an income, please provide a letter of financial support.

Please attach adequate verification of the income listed below along with the most recent Federal Tax return.

Name of Person	Gross Yearly Income	How often paid	Source of Income
TOTAL INCOME			

Section IV – Statement of Understanding I understand that my case is confidential, and no information will be released unless I authorize it.

I certify that I have read all statements on this application and that the information given is true and complete to the best of my knowledge. By my signature, I authorize the release of any information needed to determine my eligibility for the Riverside Pediatrics Sliding Fee Discount Program.

Applicant Signature: _____ Date: _____