Rural Medical Services
PO Box 577
Newport, TN 37822
423-613-3300

SLIDING FEE APPLICATION

(Requires Proof of Income)

Name of Patient____
Head of Household____
Address____
Phone Number______________________________
Social Security #____________________________
Employer____
Number in Household__________________
Household Income_______________ ☐Week ☐Month ☐Year

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I hereby certify that the above information and attached documentation as to proof of income is true and correct. I understand that I am personally responsible for any expense arising out of false information I have submitted. I understand that my account will be billed for any discount provided on this date if it is determined by the Administrative Office Review that I do not qualify for all or part of the discount provided. I understand that I must be re-certified in one year to receive this reduced scale and I must report any changes in financial status to this office. I also authorize this office to contact any employer or social service agency to verify information and the proof of income provided.

_____________ ____________________________________

Date Signature of Applicant, Parent or Guardian

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Do not Write Below this Line……..For Office Use Only

Number in Famliy________

Provisional Sliding Fee Eff Date__________ End Date__________
Annual Income_________________ S/F%_____ Approved ☐ Disapproved ☐

______________________________ ____________________

Signature of PSR Date

Sliding Fee with Proof Eff Date__________ End Date__________
Annual Income_________________ S/F%_____ Approved ☐ Disapproved ☐

______________________________ ____________________

Signature of PSR Date