



Falls Community Hospital and Clinic

Phone: 254-803-3561 ext 2374

PO Box 60
Marlin TX 76661

Fax: 254-803-6908

WHAT YOU WILL NEED TO BRING

- 1) Current proof of ALL Income for everyone living in the household:
(Example: last 3 paycheck stubs, income tax return for prior year, child support, food stamp information, SSI award letter etc...)
- 2) Proof of Residence that has your name and address listed, **NO P.O. Boxes:**
(Examples: any utility bill, bank statement, etc...)
- 3) Driver's license or photo ID and Social Security Card.

These are the documents you will need in order to be approved for financial assistance. I must have everything listed above before I can qualify you for the program.

Thank you,

Misty Powers

IHC Coordinator/Financial Assistance

Discounted/Sliding Fee Program

Name of Head of Household: _____ Phone _____

Address: _____ City _____ State _____ Zip _____

Place of Employment: _____

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Income Information

Source (Monthly)	Self	Spouse	Other	Total
Gross wages, salaries, tips etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support assistance from outside the household, and other miscellaneous sources				
Total Income				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) _____ Date _____

Signature _____

Office Use Only			
Patient Name	Discount		
Date of Service	Approved by		
Verification Checklist (attach copies)	Yes	No	
Identification/Address: Driver's license, utility bill, employment ID or other			
Income: Prior year's tax return, three most recent pay stubs or other			
Insurance: Insurance card(s)			



Letter of support

Patient medical record number/account number _____

Supporter's name _____

Relationship to patient/applicant: _____

Supporter's address _____

To Falls Community Hospital and Clinic:

This letter is to advise that (patient's name) _____ receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter _____

Date _____