LEESBURG PEDIATRICS

Family Assistance Plan Application

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE
HEALTH INSURANCE PLAN			SOCIAL SECURITY NUMBER	

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				

Source	Self	Spouse	Other	Total
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
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, birth certificate, employment ID, social security card or other	☐	☐
Income: Prior year tax return, three most recent pay stubs, or other	☐	☐
Insurance: Insurance card(s)	☐	☐
Medicaid: Application made or evidence of rejection	☐	☐

Services Covered and Excluded

Leesburg Pediatrics
1006 N. 14th Street
Leesburg, FL 34748

Discounted/ Sliding Fee Application

It is the policy of Professional Pediatrics to provide essential services regardless of the patients ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or a member of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drug, and x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This for must be completed for each visit. Please inquire at the front desk if you have any questions.

Number of related persons living in your household: [ ]

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and public aid.

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 [ ]