Karen L. Smith, MD, PA

The Power of Touch

Karen L. Smith, MD, PA

Family Practice

929 West Prospect Avenue

Raeford, NC 28376

P: 910-904-1695 F: 910-904-1767 E: info@karensmithmd.com

Discount/ Sliding Fee Schedule Program

Karen L. Smith. MD. PA

The practice of Karen L. Smith, MD, PA is a family medical practice that provides comprehensive primary care, preventive care, community health, medication assisted treatment, and other health-related services to residents of its community, regardless of the individual's or the family's ability to pay.

The practice of Karen L. Smith, MD, PA will assist patients in determining if they are eligible to participate in our Discount/ Sliding Fee Program. Patient's must provide the following information and complete this application to be enrolled in the Discount/ Sliding Fee Program.

If eligible, this Discount/ Sliding Fee Program will only apply to services rendered at and by the practice of Karen L. Smith, MD, PA and Karen L. Smith, MD, FAAFP.

Patient will need to provide recent proof of income for all family members/ individuals living in the household. The following are acceptable forms of proof of income:

- Previous year 1040 tax form
- At least one month pay stub (must be most recent pay stub)
- 1 unemployment stub (must be most recent unemployment stub)
- Food Stamp award letter
- Copy of Social Security or Disability Check
- Letter from employer that states your salary or wages

Eligibility and discount amount for those patients that qualify will be determined using the 2021 Slide Fee Schedule and the 2021 Federal Poverty Guidelines.

I certify that, I, ____, have read the entirety of this form and acknowledge that I am seeking approval for the Discount/ Sliding Fee Program offered to patients of Karen L. Smith, MD, PA. I understand that my eligibility can only be determined by providing one of the above listed documents. I understand that my discount is already pre-determined based off my level status associated with my income and household size. I understand that I am expected to uphold integrity and provide unaltered, legitimate documentation. I understand that my eligibility will be re-evaluated annually to assess need for enrollment status. Upon request, I will provide additional documentation that attests to my most current income and household size.

If you agree to the above statement, please print, and sign your name below followed by the date of signing.

Print Name ____

Signature ____

Date ____

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Sliding Fee Discount Application
Financial & Household Information

Name ____

DOB _____/_______/________

Street Address ____
City ________________________ State ____________________ Zip Code ____________
Phone Number _________________________________
Email ____

Please list all household members, including those under age 18.

	Name	**Date of Birth**
Self		
Other		
Other		
Other		
Other		
Other		
Other		

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Please complete financial information.

Source	Self	Other	Total	
Gross wages, salaries, tips, etc.				
Income from business and self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income				
Interest; dividends; royalties; income from rental properties, estates, and trusts; 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.

Name (Print) ____ Date __________________

Signature ____ Date ___________________