Bailey Medical Low-Income Program Application

This form may be faxed to us at 805-528-1461 or mailed to the address below.
You may also call us 800-413-3216 to complete the application over the phone.

1. Personal Information:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: ( ) _____

Email: _____

2. Check the total number of persons in your household:

	Total Combined Annual Income
❑ One (1)	My qualifying income is less than $31,900
❑ Two (2)	My qualifying income is less than $38,700
❑ Three (3)	My qualifying income is less than $45,500
❑ Four (4)	My qualifying income is less than $52,300
❑ Five (5)	My qualifying income is less than $59,100
❑ Six (6)	My qualifying income is less than $65,900
❑ Other _____	Each Additional $6,800

3. Declaration and Self-Certification:

I state the information I have provided in this application is true and correct. By submitting this application I certify that I have read, understand and qualify for the discount offered to those with a reduced income based on the income guidelines below. After submitting a qualifying application I will receive a promotional code for discount allowance.

_____ _____
Signature Date

Bailey Medical Engineering 2216 Sunset Drive Los Osos, CA 93402
phone 800-413-3216 fax 805-528-1461
www.baileymed.com folks@baileymed.com