

# Income Assessment Form

## Application for Sliding Scale Discount

TODAY'S DATE: \_\_\_\_\_

PROOF OF INCOME DUE DATE: \_\_\_\_\_

Payment is expected at time of service. Because you have indicated there are financial barriers preventing you from paying the full fee associated with your visit(s), you have the opportunity to apply for a sliding scale discount by completing this form. Proof of income is **required** to determine eligibility.

- If income verification is not submitted at this visit, you will not be eligible for the sliding scale. However, if you **submit income verification within 30 days of today's date**, your self pay portion will be adjusted to the sliding scale percentage you are eligible for, if any, per your documentation.
- If proof of income is received **after 30 days**, your sliding scale discount will begin the date we receive your proof of income. It will not be retroactive and you will owe full fee for visits received prior to the date you brought your documentation.

The following sources of income should be included when computing gross income: (Income before taxes/deductions are taken out)

Salaries, wages, tips, commissions	Public Assistance	Unemployment Compensation
Workman's Compensation	Veteran's Benefits	Social Security cash benefits
Alimony and child support payments	Pensions	Net investment income (rent, interest, dividends)
Net earnings from self-employment	Business Profits	Other cash income or readily available to the family

Acceptable forms of income documentation include:

Current payroll or check stubs	Award letter	Tax returns
Current Commissions statement	Court documents	Current Bank Statements
Letter (signed and dated) from representative		

You will be asked to complete this form and provide updated proof of income annually, or sooner if change in Income or family size occurs.

I have read this and understand what is required of me.  
Initial: \_\_\_\_\_

### PATIENT INFORMATION:

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

What is your current housing status:

- Not Homeless     
  Transitional     
  At risk for homeless     
  Living in shelter/gospel mission  
 Street, camp or bridge     
  Living with others (more than one family per home)  
 Currently not homeless, was in last 12 months

### PERSON WHO IS RESPONSIBLE TO PAY BILL AT TIME OF SERVICE (RESPONSIBLE PARTY):

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

### INCOME INFORMATION:

FAMILY SIZE: \_\_\_\_\_ (All persons in the same household who are related by blood, marriage, legal adoption and/or meet the definition of a tax dependant.)

GROSS MONTHLY INCOME: \$ \_\_\_\_\_ (For all people you declared in your household.)

INCOME SOURCE: (CHECK ALL THAT APPLY):

- |                                                                                                                        |                                                             |                                             |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Public Assistance (Food Stamps, etc)                                                          | <input type="checkbox"/> Salaries, Wages, Tips, Commissions | <input type="checkbox"/> Social Security    |
| <input type="checkbox"/> Workman's Compensation                                                                        | <input type="checkbox"/> Alimony and Child Support Payments | <input type="checkbox"/> Pension            |
| <input type="checkbox"/> Net Investment Income (rent, interest, dividends)                                             | <input type="checkbox"/> Unemployment Compensation          | <input type="checkbox"/> Business Profits   |
| <input type="checkbox"/> Other cash income or allowances from any resources which are readily available to the family. | <input type="checkbox"/> Net Earnings from Self-Employment  | <input type="checkbox"/> Veteran's Benefits |

BY SIGNING BELOW, I ACKNOWLEDGE THAT ALL INFORMATION I HAVE PROVIDED IS ACCURATE AND TRUE, I AGREE TO THE ABOVE POLICY AND I HAVE HAD ALL OF MY QUESTIONS ANSWERED TO MY SATISFACTION:

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\*\*\*\*\*FOR CNHF USE ONLY\*\*\*\*\*

VERIFIED GROSS MONTHLY INCOME: \$ \_\_\_\_\_ VERIFIED FAMILY SIZE: \_\_\_\_\_ DISCOUNT ELIGIBLE FOR: \_\_\_\_\_%

Current Payroll or Check Stub     
  Award Letter     
  Court Documents     
  Tax Returns     
  Current Commissions Statement  
 Bank Statement     
  Letter From: \_\_\_\_\_     
  Other: \_\_\_\_\_

Homeless Verified? Yes / No      EPIC MRN: \_\_\_\_\_      date input into EPIC: \_\_\_\_\_      verified by: \_\_\_\_\_