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 every 6 months, 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):

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

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 LCHHS 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 Ochin MRN: __________________ date input into Ochin: _____________ verified by:_________

Original = Chart Copy = Patient/Guardian Revised 8/25/2010

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