

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 slide 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
Workman's Compensation
Alimony and child support payments
Net earnings from self-employment

Public Assistance
Veteran's Benefits
Pensions
Business Profits

Unemployment Compensation
Social Security cash benefits
Net investment income (rent, interest, dividends)
Other cash income or readily available to the family

Acceptable forms of income documentation include:

Current payroll or check stubs
Current Commissions statement
Letter (signed and dated) from representative

Award letter
Court documents

Tax returns
Current Bank Statements

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):

- ☐ Public Assistance (Food Stamps, etc) ☐ Salaries, Wages, Tips, Commissions ☐ Social Security
☐ Workman's Compensation ☐ Alimony and Child Support Payments ☐ Pension
☐ Net Investment Income (rent, interest, dividends) ☐ Unemployment Compensation ☐ Business Profits
☐ Other cash income or allowances from any resources which are readily available to the family. ☐ Net Earnings from Self-Employment ☐ 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 ANNUAL INCOME: \$ _____ VERIFIED FAMILY SIZE: _____ SLIDE 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 _____ IMS MRN: _____ date input into iMS: _____ verified by: _____