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 CompensationWorkman’s Compensation Veteran’s Benefits Social Security cash benefitsAlimony 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 StatementsLetter (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:

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:

**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 dependent.)*

GROSS MONTHLY INCOME: $

(*For all people you declared in your household.)*

**INCOME SOURCE: (CHECK ALL THAT APPLY):**

Public Assistance (Food Stamps, etc) Workman’s Compensation

Net Investment Income (rent, interest, dividends)

Salaries, Wages, Tips, Commissions Alimony and Child Support Payments Unemployment Compensation

Net Earnings from Self-Employment

Social Security Pension Business Profits

Veteran’s Benefits

Other cash income or allowances from any resources which are readily available to the family.

PATIENT/GUARDIAN SIGNATURE: DATE:

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

Current Payroll or Check Stub Bank Statement

Homeless Verified? Yes / No

Award Letter

Court Documents

Tax Returns

Current Commissions Statement

Letter From:

Other:

Ochin MRN:

date input into Ochin:

verified by:

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

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