2022 Inc/Ins Form

Family Health Care
Patient Self Declaration of Insurance and Income Form

Insurance Information:

□ Medicare □ Medicaid □Other:_____ □ Secondary: _____

Income Information:

As a Federally Qualified Health Center, Family Health Care must collect income information to see if you are eligible for reduced fees. The following form must be completed and signed along with **proof of income (see listing on back side for acceptable forms of income).**

SOURCES OF INCOME: All members living in the family/household. "Family/Household" is considered to be all persons living with you at the same address that are financially dependent on you or that you are dependent on. If living situation is temporary, please tell FHC staff.

Source	Amount ($)	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages (self)		□	□	□	□
Salaries and Wages (spouse)		□	□	□	□
Salaries and Wages (other)		□	□	□	□
Worker's Comp (SIIS)		□	□	□	□
Social Security (Self/Spouse)		□	□	□	□
Social Security (Children)		□	□	□	□
SSI (Supplemental Security)		□	□	□	□
Child Support / Alimony		□	□	□	□
Military / Veterans Benefits		□	□	□	□
Unemployment Benefits		□	□	□	□
Other Family Members		□	□	□	□

HOUSEHOLD SIZE: List all household members by NAME, DATE OF BIRTH, and RELATIONSHIP, **include yourself**:

Name	Date of Birth	Relationship

If more space is needed, please write remaining family/household members on blank space on back side of form.

Gross Household Income (Before Taxes):

$_____ □ Monthly □ Annually

OR

☐ **I prefer not to disclose income. By choosing not to disclose my income, I understand that I will be responsible for any balance not paid by third party insurance.**

PLEASE READ THE FOLLOWING CAREFULLY

I declare that my household's financial status is as listed above. I understand the following:

- Family Health Care is utilizing federal tax dollars to assist me in receiving health care
- Giving false information regarding my household income can be considered fraud
- Any change in my finances or the number of people in my family/household must be reported to Family Health Care and a new application must be completed

Patient/Guarantor Signature_____ Date_____

Accepted Proof of Income

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040-1040 EZ Form)
- Printout from government office issuing payments (SS, SSI, SSD, unemployment, VA, etc)
- 2 most recent paystubs
- Pension payments, Veteran's Benefits
- Employer letter for cash wages (must include employer name, signature, address and phone number)
- Court order for alimony or child support or printout for child support payments
- Award letter (student grants, stipends, etc.)
- Letter from caregiver
- Identification from the Department of Corrections if patient is currently incarcerated.
- Letter from a Homeless shelter, e.g. Shalom House

Additional Family/Household members (if necessary)

Name	Date of Birth	Relationship

Patient Acknowledgement of Interpreter Services

I acknowledge that all forms were completed by myself or my guardian through an interpretation service.

Patient/Guardian Signature_____ Date_____

For Office Use Only:

Guarantor #: _____

Patient Proof of Income:

☐ Patient Declined

☐ Awaiting

☐ Received

POI Document Type Received (write all applicable):_____

Received Date: _____ POI info entered by: _____

Calculated Gross Income: $_____ □ Monthly □ Annually Household Size: _____

Sliding Fee Scale Level Approved:	Nom Fee	1	2	3	4	FHC Full

POI action created to billing for Review for past dates of service for adjustments: □ Yes □ N/A

Form Completed By: _____ Date: _____