neighborhood health center

INCOME VERIFICATION FORM

Patients who would like to apply for the sliding fee discount must declare their interest at the time of their visit. They must also fill out an income verification form and provide proof of income as described below.

Patients can self-declare their income on their initial visit only. To apply they must fill out the income self declaration form and will not receive a sliding fee discount until after the initial visit unless they provide proof of income as described below.

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify Neighborhood Health Center Clinic of that change.

(*) Patients are required to give at least one of the following items as verification of income:

1. Previous year tax returns
2. Previous year W-2
3. Current pay stubs (last 4 weeks, if possible)
4. Lay-off notice from last employer
5. Check stubs from Unemployment (last 4, if possible)

Patient Name: _____ **Date of Birth:**_____

Eligibility for the sliding fee scale is based on total household income. Please list all family members within this household who are applying for the sliding fee discount using their combined income.

Family Member : _____ Date of Birth:_____

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Number of Family Members: _____ Monthly Payroll Amount $ _____

Payroll Frequency: _____ Weekly _____ Bi-Weekly _____ Semi-Monthly _____ Monthly

Signature of Patient or Personal Representative: _____**Date:** _____

2010 FEDERAL POVERTY GUIDELINES	
Family Size	**Monthly Income**
	200% or Less
1	1,805.00
2	2,428.33
3	3,051.67
4	3,675.00
5	4,298.33
6	4,921.67
7	5,545.00
8	6,168.33
Family units more than 8 members, add $312 for each additional member	

INCOME SELF DECLARE INFORMATION

Self-Declaration of your household income entitles the patient to receive discounted services for their FIRST visit only. Proof of income is required to discount all future visits

No. of Family Members: _____ Monthly Payroll Amount $ _____

Payroll Frequency: _____ Weekly _____ Bi-Weekly
_____ Semi-Monthly _____ Monthly

U.S. Veteran? _____ Yes _____ No
Farmer Worker Status: _____ None _____ Migrant _____ Seasonal

Signature of Patient or Personal Representative:_____
Date: _____