

**Why do we need to know your household income?**

* Some of our funding comes from grant money. For most of these grants, income information from our patients is necessary to prove financial need in the communities we serve.
* These grants allow us to provide a much higher level and greater availability of care than we could otherwise afford.
* In order to obtain these grants, and to keep them, we need to provide demographic information, including financial resources of patients, to prove that we are serving the people the grant money has been set aside for.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **I UNDERSTAND THAT:** | |  |  |  |
| **1** | The financial information I provide must be renewed each year unless there is a change in my current financial status prior to the renewal, in which case I must notify LCHC at the time of service at my next visit and provide proof of the change. |  |  | *Initials* |
| **2** | I must provide proof of my residence and will notify LCHC promptly of any address change. |  |  | *Initials* |
| **3** | Proof of income is required at the time of visit, failure to provide acceptable documentation will result in being charged full price with no application of any discount. |  |  | *Initials* |
| **4** | First time patients will be allowed 30 days in which to submit required proofs of residence or income and **that failure to do so will result in being responsible for the full amount of charges without any discount.** I understand that I will be required to pay the sliding fee discount prices at the time services are rendered. |  |  | *Initials* |

**Proof of Income (Employed)** **Proof of Income (Unemployed)** **Proof of Address**

- Current 1040 or other tax return - Public Assistance Check stub/copy - Utility bill in patients name

- 2 recent pay stubs - Social Security check stub - Drivers License

- Written & Signed document from - Letter from non-profit (e.g. church) - Any recently received mailing

the employer - Certification letter from DHS in patients name

- Notarized letter of person providing - Notarized letter of person

Individuals’ support whom has knowledge of residence

**Please list ALL household members:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Date of Birth | Social Security # | Relationship to Patient | How Often Paid  (Weekly, Bi-Weekly, Monthly, Bi-Monthly) |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |

**\*\*Patients applying for the sliding fee program are OBLIGATED to contact Lawton Community Health Center if the INCOME and/or HOUSEHOLD STATUS changes, or if they become eligible for INSURANCE. \*\***

**I certify that the household size and income information given is correct. I agree to pay my portion of total charges for each service at the time of services**

**Printed Name Signature Date**

**□ I DECLINE TO PROVIDE MY HOUSEHOLD FINANCIAL INFORMATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_ Date**

|  |  |  |  |
| --- | --- | --- | --- |
| **For Office Use Only:** |  |  |  |
| Total # of members in household: | \_\_\_\_\_\_\_\_ | Total household YEARLY income: | \_\_\_\_\_\_\_\_ |
| Total household WEEKLY income: | \_\_\_\_\_\_\_\_ | SLIDING FEE CATEGORY: | \_\_\_\_\_\_\_\_ |
| Total household BI-WEEKLY income: | \_\_\_\_\_\_\_\_ | Total MONTHLY income: | \_\_\_\_\_\_\_\_ |
|  |  | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |