Apicha Community Health Center

Financial Screening Form

The discount will apply to medical services received at this clinic, but not medications/immunizations and those services which are purchased from outside, including reference laboratory testing, drugs, X-ray interpretation by a consulting radiologist, and other such services.

Let the Eligibility Associate know if you have any questions.

Number of related persons living in your household:_____

Total household income: (complete one column)

Household Member	**Household Income (complete one column)**		
	Annual	Monthly	Bi-weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

_____ _____

Name (Print) Signature and Date

Office Use Only

Patient Name: _____ Discount: _____

Date of Service: _____ Approved by: _____

Apicha Community Health Center

Verification of Income

Verification check list (attach copies)	**Yes**	**No**
identification/address: driver's license, birth certificate, employment ID, social security card, other		
Income: Prior year tax return, three most recent pay stubs, other		
Insurance: insurance card(s)		
Medicaid: application made or evidence of rejection		
Patient self attestation		

Patient is unable to produce verification of income; producing verification of income is a barrier to care.

Please describe reason for inability to produce above documentation:

_____

_____

_____

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Patient Name (Print) Signature and Date

Office Use Only

Pay class approved: _____ Effective Date: _____

Approved by: _____ Expiration Date: _____