

Patient Household and Income Information

Head of Household's First Name	MI	Head of Household's Last Name	Head of Household's DOB	Today's Date
Person Completing Form: <input type="checkbox"/> Self (head of household) <input type="checkbox"/> Other (specify):				

It is the policy of Finger Lakes Community Health to provide essential services regardless of the patient's ability to pay. Discounts are based on family size and annual income. A computerized sliding fee schedule is used to calculate the basic discount and is updated yearly by using the federal poverty guidelines. Once approved the discount will be honored for one year from the date of enrollment, unless new income information and verifying documents are received prior to the anniversary date. All patients whether insured or not may apply for a discount.

List spouse and dependents (ask for additional sheets if more than 5 household members)			
Name	Date of Birth	Relationship	Patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Income Information						
How is the head of household paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other:						
Pay Amount: \$	How many hours are worked per week?					
How many months of the year does this person work?	Does income vary based on the season? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Income Information other household member						
How is the other household member paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other:						
Pay Amount: \$	How many hours are worked per week?					
How many months of the year does this person work:	Does income vary based on the season? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>Should you have any other salaries to report please ask for the Additional Household Members and Income Worksheet</i>						
Other Types of Income (report monthly amount received for each)						
SSI/SSD	Unemployment	Social Security	Pension	Disability	Workers Compensation	Monthly Total
\$	\$	\$	\$	\$	\$	

Initial all that apply and sign at the bottom:

_____ I certify that the information and documentation provided are a complete record of the household income. I understand that it is my responsibility to notify FLCH of any changes to my household's financial situation, unless I am choosing not to apply for any eligible discounts.

_____ I understand that I will need to supply proof of income within 90 days of my initial visit in order to continue to receive discounted services.

_____ I understand that I will be required to complete this application and provide proof of income annually in order to continue to receive discounted services.

_____ At this time I chose not to apply for discounted services, and I am aware that I will pay full fee for any services that are not covered by my insurance plan. I am aware that I can apply for a discount at a later date by completing this form and providing the necessary proof of income.

Signature

Date