DOCUMENTED VERIFICATION OF INCOME/FAMILY SIZE

DATE OF SERVICE_____

(Attach copies of proof of income, such as paycheck stubs, income tax returns, etc.)

Always make copies, never hand over originals you may need for use later.

ANNUAL INCOME_____

FAMILY SIZE_____

A PREGNANT WOMAN WILL COUNT AS TWO IN THE FAMILY

SLIDING FEE_____

I certify that the information I have provided is correct, to the best of my knowledge. I understand that I will be held responsible for any consequences (e.g. payments, fines, legal action, etc.) resulting from intentionally providing false or misleading information.	Signature of person responsible for this account Date

Whiteside County Community Health Clinic Sliding Fee Scale 2018

Family Size	Level 1 Slide $25 Flat Fee*	Level 2 Slide Medical or BH* $30 Flat Fee / Dental 20% of Full Fee	Level 3 Slide Medical or BH* $45 Flat Fee / Dental 40% Full Fee	Level 4 Slide Medical or BH* $65 Flat Fee / Dental 60% of Full Fee	Level 5 Slide Medical or BH* $85 Flat Fee / Dental 80% of Full Fee	Level 6 No Discount Full Fee
1	$0 $12,140	$12,141 $15,175	$15,176 $18,210	$18,211 $21,245	$21,246 $24,280	$24,281
2	$0 $16,460	$16,461 $20,575	$20,576 $24,690	$24,691 $28,805	$28,806 $32,920	$32,921
3	$0 $20,780	$20,781 $25,975	$25,976 $31,170	$31,171 $36,365	$36,366 $41,560	$41,561
4	$0 $25,100	$25,101 $31,375	$31,376 $37,650	$37,651 $43,925	$43,926 $50,200	$50,201
5	$0 $29,420	$29,421 $36,775	$36,776 $44,130	$44,131 $51,485	$51,486 $58,840	$58,841
6	$0 $33,740	$33,741 $42,175	$42,176 $50,610	$50,611 $59,045	$59,046 $67,480	$67,481
7	$0 $38,060	$38,061 $47,575	$47,576 $57,090	$57,091 $66,605	$66,606 $76,120	$76,121
8	$0 $42,380	$42,381 $52,975	$52,976 $63,570	$63,571 $74,165	$74,166 $84,760	$84,761
For each additional family member	$4,320	$5,400	$6,480	$7,560	$8,640	
CHC Target Population	To 100% of poverty	To 125% of poverty	To 150% of poverty	To 175% of poverty	To 200% of poverty	Over 200% of poverty

***Minimum $25 fee for Medical, Dental and Behavioral Health. The minimum $25 fee does not include Dental elective or pre-paid procedures. Additional Behavioral Health grants and adjustments may apply**

Interviewer's Signature _____

PROOF OF INCOME WORKSHEET **(for employee use ONLY)**

Patient name _____

Number of people in family_____

Enter gross amount _____

_____

_____

_____

If they get paid weekly take gross amount add it together, total amount divided by 4 then times 52.

Total amount _____

Amount divided by 4 _____

Amount times 52 _____
This amount is your yearly income

If they get paid biweekly take gross amount add it together, total amount divided by 2 then times 26.

Total amount _____

Amount divided by 2 _____

Amount times 26 _____
This amount is your yearly income

If they get paid bimonthly take gross amount add it together, total amount divided by 2 then times 24.

Total amount _____

Amount divided by 2 _____

Amount times 24 _____
This amount is your yearly income

Completed By_____ Date_____

Definition of Family: One or more adults and children related by blood or law and residing in the same household. Where adults other than the spouse reside together each should be considered a separate family.

DISCOUNT SLIDING SCALE FEES ELIGIBILITY CRITERIA

The Whiteside County Community Health Clinic is a federally qualified health center that provides primary and preventative health care services to individuals who have limited access to health care due to the lack of financial resources or health insurance. To ensure that income or lack of insurance is not a barrier to care, low-income patients who are not covered by public or private insurance are charged on a sliding fee scale.

1. The Clinic uses the Federal Poverty Income level guidelines to determine the discount the patient will receive based on their income and family size.
2. If a patient wishes to be evaluated for the Clinic's sliding fee scale, they MUST bring information regarding their house hold income with them when they come to their initial appointment. Patient will be charged full fee until proof of income is provided. Patient will be charged full fee until proof of income is provided.
3. To continue to qualify for sliding fees, the patient will need to bring income information once a year.

ACCEPTABLE FORMS OF PROOF OF INCOME:

1. Two pay stubs within the last thirty days
2. Last year's tax return
    a. Gross income before deductions for income taxes, employees' social security taxes, insurance premiums, etc...
3. Other income records
    a. (i.e. Employment Verification Statement, Verification of Support Statement; Self Employment Record; "0" Income Affidavit)

Income figured on base pay