

**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.

Patient Sticker

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 2019

Family Size	Level 1 Slide \$25 Flat Fee*	Level 2 Slide	Level 3 Slide	Level 4 Slide	Level 5 Slide	Level 6 No Discount Full Fee
		Medical or BH* \$30 Flat Fee Dental 20% of Full Fee	Medical or BH* \$45 Flat Fee Dental 40% Full Fee	Medical or BH* \$65 Flat Fee Dental 60% of Full Fee	Medical or BH* \$85 Flat Fee Dental 80% of Full Fee	
1	\$0 \$12,490	\$12,491 \$15,613	\$15,614 \$18,735	\$18,736 \$21,858	\$21,859 \$24,980	\$24,981
2	\$0 \$16,910	\$16,911 \$21,138	\$21,139 \$25,365	\$25,366 \$29,593	\$29,594 \$33,820	\$33,821
3	\$0 \$21,330	\$21,331 \$26,663	\$26,664 \$31,995	\$31,996 \$37,328	\$37,329 \$42,660	\$42,661
4	\$0 \$25,750	\$25,751 \$32,188	\$32,189 \$38,625	\$38,626 \$45,063	\$45,064 \$51,500	\$51,501
5	\$0 \$30,170	\$30,171 \$37,713	\$37,714 \$45,255	\$45,256 \$52,798	\$52,799 \$60,340	\$60,341
6	\$0 \$34,590	\$34,591 \$43,238	\$43,239 \$51,885	\$51,886 \$60,533	\$60,534 \$69,180	\$69,181
7	\$0 \$39,010	\$39,011 \$48,763	\$48,764 \$58,515	\$58,516 \$68,268	\$68,269 \$78,020	\$78,021
8	\$0 \$43,430	\$43,431 \$54,288	\$54,289 \$65,145	\$65,146 \$76,003	\$76,004 \$86,860	\$86,861
For each additional family member	\$4,420	\$5,525	\$6,630	\$7,735	\$8,840	
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 _____

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

Number of people in family _____

Total amount _____

Enter gross amount _____

Amount divided by 2 _____

Amount times 26 _____

This amount is your yearly income

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

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

Total amount _____

Total amount _____

Amount divided by 4 _____

Amount divided by 2 _____

Amount times 52 _____

Amount times 24 _____

This amount is your yearly income

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.

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 household income with them when they come to their initial appointment. 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