CHCFC
Community Health Center of Franklin County

Chart #_____

PI Date: _____

Intake Initials: _____

Patient Intake Calculation Form

Income 1:_____

Type of income: ☐ Pay checks ☐ Unemployment ☐ Child Support ☐ Other

Pay frequency: ☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Bi-Monthly (24) ☐ Monthly (12)

1.) _____ 5.) _____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

Total: _____ divided by ____= _____x _____=_____annually

Income 2:_____

Type of income: ☐ Pay checks ☐ Unemployment ☐ Child Support ☐ Other

Pay frequency: ☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Bi-Monthly (24) ☐ Monthly (12)

1.) _____ 5.) _____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

Total: _____ divided by ____= _____x _____=_____annually

Miscellaneous Income:

Other monthly income (SSI, FIP, _____) _____x _____ =_____annually

Other monthly income (SSI, FIP, _____) _____x _____ =_____annually

Calculations Explained/Notes:

_____

_____

_____

Total Annual Income _____ ☐ No Income – signed income sheet

Family Size____ Discount Level _____% Expires_____

***Helpful Hint**
Bi-Weekly Pay: add gross amounts from 2 paystubs (4 weeks total pay), divide by 2 (to get biweekly amount) and multiply by 26

Audited By: _____ Date: _____

Correct: ☐

Incorrect: ☐ _____

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Patient Intake Calculation Form

I hereby certify that I have chosen to apply for the Sliding Fee Scale application. This application is used to determine if a discount can be provided to me based on the information I provide. I understand I must provide all information requested including but not limited to household structure and income.

The discount is provided on all procedures with the exception of additional fees associated with certain procedures. The discount is determined by the household's income as it relates to the Federal Poverty Level.

I also understand that if this information changes I must notify The Community Health Center of Franklin County's Outreach and Enrollment Staff for a redetermination of my sliding fee discount. I know that I must provide a new application within 12 months of the previous application provided, even if my information has not changed.

By signing below I certify that the information I provided above is complete and correct to the best of my ability.

Signature of Patient/Guarantor: _____ Date: _____

Patient Printed Name: _____ Phone: _____

Guarantor's Printed Name (if different): _____

This application was witnessed by the Outreach and Enrollment Staff member listed below:

Staff Signature: _____ Date: _____

Staff Printed Name: _____

Sliding Fee Verification Documents

Items needed for verification process:

_Completed intake calculation sheet with signature (chart number, family size completed)

_Copies of insurance, Medicaid, Medicare, or other program participation documentation

_Proof of Income

_Proof of Residency

Acceptable Proof of Income:

_1 month of paystubs

_Income Tax Forms (showing annual gross income) with W2

_Social Security statement

_Bank statements (for pension)

_Statements from employers that state gross pay per pay period

_Child support & alimony court papers

_Self-employed & Rental: Federal ax return with schedule C (self-employed) or E (rental)

Acceptable Proof of Residency:

_ Federal income tax return

_Lease or mortgage

_Real estate bill

_Rent receipt

_Current utility bill

_Notarized landlord affidavit

Exceptions:

Patient has started new job and only has one paycheck stub. Will be placed on Review Pending for 30 days.

Patient can be verified for one day for Pharmacy services.