

Shawnee Health Service
FAMILY INCOME SCREEN

What is this information for? Many families today have a hard time paying for health care due to their income. Shawnee Health Service is able to help families receive financial assistance for care provided by our Doctors and Dentists. In order to do this, we must report the income levels of the families we serve to the Bureau of Primary Health Care, who provides us with grant dollars. The information reported is in summary form—an individual’s income level is NOT reported. Please help us continue to receive these grant dollars by completing the following two questions:

1. Please tell us about the family member(s) living in your home (this means people related by blood, marriage or adoption and children that you support but may be attending school away from home).

Family Member Name (include your name)	Relationship	Birth Date	SIU Student	Medical Ins	Dental Ins	Medicaid
_____	_____	_____	Yes No	Yes* No	Yes* No	Yes* No
_____	_____	_____	Yes No	Yes* No	Yes* No	Yes* No
_____	_____	_____	Yes No	Yes* No	Yes* No	Yes* No
_____	_____	_____	Yes No	Yes* No	Yes* No	Yes* No
_____	_____	_____	Yes No	Yes* No	Yes* No	Yes* No
_____	_____	_____	Yes No	Yes* No	Yes* No	Yes* No

Total Family Size _____ *Attach copy of card(s)

2. Please tell us about your Family Income. Find Your Family Size in the column on the left, then go across that line and circle your family take home pay (net income) range in the same line.

Family Size	Net Income Range A	Net Income Range B	Net Income Range C	Net Income Range D
1	\$0 to \$9,809	\$9,810 to \$14,705	\$14,706 to \$19,601	\$19,602 & above
2	\$0 to \$13,205	\$13,206 to \$19,805	\$19,806 to \$26,405	\$26,406 & above
3	\$0 to \$16,601	\$16,602 to \$24,905	\$24,906 to \$32,201	\$32,202 & above
4	\$0 to \$20,009	\$20,010 to \$30,005	\$30,006 to \$40,001	\$40,002 & above
5	\$0 to \$23,405	\$23,406 to \$35,105	\$35,106 to \$46,805	\$46,806 & above
6	\$0 to \$26,801	\$26,802 to \$40,205	\$40,206 to \$53,609	\$53,610 & above
7	\$0 to \$30,209	\$30,210 to \$45,305	\$45,306 to \$60,401	\$60,402 & above
8	\$0 to \$33,605	\$33,606 to \$50,405	\$50,406 to \$67,205	\$67,206 & above

Each additional Person \$3,400

If you circled an income range in column D, we thank you for taking the time to complete this form. Please give this paper to the receptionist.

If you circled an income range in Column A or B or C, you may qualify for discounted medical and dental services for today’s charges ONLY. If you wish to qualify for discounted charges after today, please complete the other side of this form.

SHAWNEE FINANCIAL ASSISTANCE PROGRAM APPLICATION

To be able to continue to receive discounts for care you receive, you must provide proof of your family household income. A copy of one of the following items may be used to provide proof of your family income:

- Copy of your 1) most recent IRS form, W2 Wage and Tax Statement or a copy of your checks or check stubs from your employer, and 2) copy of Social Security, pension, unemployment, worker's comp or any other source(s) of income you have received for past 90 days.
OR -----
- Copy of your completed Federal Tax Return - If self employed, include Schedule C

(Attach proof for each income source below)

Income	Patient's Net Monthly Income	Spouse/Other Dependent's Net Monthly Income
Wages/Salary		
Social Security/Pensions/Annuities		
Unemployment or Worker's Comp Benefit		
Child Support/Alimony		
Veteran's Benefits		
Rental Income		
Other		
Total Monthly Income		

Total Family Annual Income: _____ **Net**

Please read and sign the following statement:

To the best of my knowledge, the above information is true and correct.

- I authorize my employer to release my wage information to Shawnee Health Service.
- I agree to inform the Center of any changes in my employment or financial status.
- I understand that if the above information proves to be incorrect, the discount will be changed or terminated.

Responsible Party Employer

Spouse or dependent employer

Employer Name _____

Address _____

City/State/Zip _____

Phone/Fax _____

**Patient/
Responsible Party Signature** _____

Date _____

SS#: _____

Spouse Signature _____

Date _____

SS# _____

For Office Use Only

Annual Income \$ _____ Effective Date: _____ Staff Signature: _____

Income Proof Exemption: (circle reason) Paid in Cash Unemployed Confidential Service

Category A B C _____ Expiration Date: _____ Clinic/Office Mgr Signature _____

Approval/Pending/Denial Letter Sent: _____ FIS Signature: _____

Account # Last Name First Name