FAMILY CARE HEALTH CENTERS
PATIENT PROOF OF INCOME REQUIREMENT POLICY

Patients are to present proof of their income on a yearly basis due by April 16. New patients presenting without proof will be rescheduled at a time when they are able to provide their proof to us. (This statement does not pertain to Family Planning services or patients.)

Patients should be informed of this policy in the following way:

* The appointment schedulers will inform all patients about the policy and proof requirements at the time the appointment is made.

PROOF OF INCOME REQUIREMENTS

(not required for Family Planning Services)

1. Current Year Tax Return Form 1040 with W-2's attached.

   - For recent job changes – Current Tax Return Form 1040 with W-2's and 4 to 6 most current check stubs.

   - If your tax return is missing or you did not file taxes, request a copy of your transcript or proof of non filing from the IRS by calling 1-800-829-1040 or by filling out the 4506 form

   - In addition to the above, the following is a list of forms acceptable for verifying current source of income:

     - B201 letter from employment insurance agency (314) 340-4950
     - Social Security Statements
     - Child Support/Alimony Information
     - Pension Check Stubs
     - Food Stamp Eligibility Letter
     - Trust Payment Information

2. Proof of your address can include your Drivers License or Missouri State ID.

02/1998
Revised 7/2010

Family Care Health Centers

Application for Sliding-Fee Scale Adjustment

I certify that all of the information I have given to Family Health Care Centers regarding my income and/or the total income for my household, employment status and insurance and/or third-party medical coverage (including prescription benefits) is accurate and correct to the best of my knowledge. I fully understand Family Care Health Centers' federal requirements for income verification, and this has been explained to me.

I agree to notify Family Care Heath Center of any change of circumstance including address, employment status, insurance status, marital status, family size or income.

I understand that Family Care Health Centers may, at any time, verify the information I have provided by obtaining a credit check, employment verification or other methods. I also understand that if the income information I have given Family Care Health Centers is found to be inaccurate, my family and/or I will be held responsible for full payment of all services and fees to Family Care Health Centers.

Responsible Party Information:

*(Complete this section **if** you are the **Parent/Guardian** of a **Minor/Dependant Patient** –OR- **you** are an **Adult Patient**)*

Responsible Party Name: _____, _____ _____
Last Name *First Name* *Middle Initial*

Street Address: _____ **Apt**: _____

City: _____ State: _____ Zip: _____

Responsible Party DOB: _____/_____/_____ **Resp. Party's Social Security No**:_____-_____-_____

Responsible Party Signature : _____ **Date Signed**: _____/_____/_____

Dependent Child's Patient Information: *(Complete this section for patients who are dependents/ minor children)*

Patient Name: _____, _____ _____
Last Name *First Name* *Middle Initial*

Patient's Date of Birth:____/____/____
MM / DD /YYYY

Household Information: (*Please complete all sections*)

Estimated Annual Household Income: $_____(*See back for "Proof-of-Income" requirements*)
Enter Number of Persons Supported by Household Income, (including yourself): _____

List Add'l Dependents' Names: (Last, First Middle Initial):	***Date of Birth:***	***Relationship:***	***FCHC Account #***
1)	/ /		
2)	/ /		
4)	/ /		
5)	/ /		
6)	/ /		
7)	/ /		
8)	/ /		

WARNING: Family Care Health Centers Reserves the right to discontinue services to any patient who knowingly falsifies or omits information!

FOR FCHC OFFICE USE ONLY: Responsible Party/Patient ***Refused to Sign***? _____ Date:____/___/____
Eligible: _____ **Ineligible**_____:_____ (*check mark, above)*
(*check one, above)*
Patient Qualifies for:_____**% *Discount*** Date of Determination: ____/_____/_____
Method of Verification: _____ **Account #**_____
FCHC Employee Name: (Print)
FCHC Employee Signature:_ _____ **Date**: _____/_____/____ -------

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*****APPLICANTS: Please see attached checklist for acceptable forms of verification*****