Ingham Community Health Centers: **Ingham County Health Department**

FAMILY INCOME INFORMATION

Patient's Name:_____ _____ _____ Patient's DOB:_____
Last Name First Name Mid Initial

Are you Homeless ☐ **Yes** ☐ No If Yes, please specify: ❒ Doubling up ❒ Not homeless ❒ Other ❒ Shelter ❒ Street

❒ Transitional ❒ Unknown/Unreported ❒ Permanent Supportive Housing (ie, AFC, assisted living, senior living).

Patient's family size and income information determines eligibility in the ICHC Sliding Fee Discount Program. Please provide us with the following information:

1) How much is the total family income? $_____ ☐ Weekly(52) ☐ Bi-Weekly(26) ☐ Monthly(12) ☐ Yearly

Please <u>do not</u> include:
- Earnings of a dependent child
- Food Stamps
- Income Tax Refunds
- Student Loans

2) How many people in the home depend on the income listed above? _____

I certify that the family size and income information shown above is correct.

Name (Print): _____

Patient/Legal Guardian Signature _____Date:_____

FAMILY INCOME VERIFICATION – (TO BE COMPLETED BY HEALTH CENTER STAFF ONLY)

Annual Income Amount: $_____

Not Eligible for Discount Program Due to:

☐ Patient Refused to Provide Income – **DO NOT ATTACH THE SLIDE**
☐ No Family Income Form Completed - **DO NOT ATTACH THE SLIDE**

Family Income Category for Sliding Fee Discount Program (please check appropriate income category)

☐FQA / FPA ☐FQB / FPB ☐ FQC / FPB ☐ FQD / FPC ☐FQE / FPC ☐ FQ Full / FPD ☐ FULL PAY

Effective Dates: _____ to _____

INFORMATION VERIFIED BY:
Staff Member:_____

Health Center Location:_____ Date: _____

Revised 01/02/20