



Rural Health Group Income Assessment

Why am I asked about my income?

Rural Health Group is a federally qualified health center (FQHC) and asks **ALL patients** about housing, veteran status, household size and income. RHG uses the household size and income to determine eligibility for the Sliding Fee Discount Program. These questions are asked regardless of insurance status. **You can still qualify for a sliding fee discount even if you have medical insurance.** We screen you for programs you may be eligible for and give you information to help you apply.

Patient Information				
Patient Name: _____	Date of Birth: _____			
If patient is under 18, Parent/Legal Guardian Name: _____	Relationship: _____			
Please check your housing/living situation: <input type="checkbox"/> Living in my own home/apartment (own or rent) <input type="checkbox"/> Living with relatives/friends <input type="checkbox"/> Experiencing Homelessness <input type="checkbox"/> Shelter/Transitional housing	Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Health Insurance Name: _____ <i>(If you have insurance, we will bill your insurance and apply the discount to any balance due for co-pays and deductibles.)</i>				
Please mark the box for your total annual household income range next to the total number of people in your household:				
A	B	C	D	E
1 <input type="checkbox"/> \$ 0 - \$15,060	<input type="checkbox"/> \$15,061 - \$20,030	<input type="checkbox"/> \$20,031 - \$25,000	<input type="checkbox"/> \$25,001 - \$30,120	<input type="checkbox"/> \$30,121 or more
2 <input type="checkbox"/> \$ 0 - \$20,440	<input type="checkbox"/> \$20,441 - \$27,185	<input type="checkbox"/> \$27,186 - \$33,930	<input type="checkbox"/> \$33,931 - \$40,880	<input type="checkbox"/> \$40,881 or more
3 <input type="checkbox"/> \$ 0 - \$25,820	<input type="checkbox"/> \$25,821 - \$34,341	<input type="checkbox"/> \$34,342 - \$42,861	<input type="checkbox"/> \$42,862 - \$51,640	<input type="checkbox"/> \$51,641 or more
4 <input type="checkbox"/> \$ 0 - \$31,200	<input type="checkbox"/> \$31,201 - \$41,496	<input type="checkbox"/> \$41,497 - \$51,792	<input type="checkbox"/> \$51,793 - \$62,400	<input type="checkbox"/> \$62,401 or more
5 <input type="checkbox"/> \$ 0 - \$36,580	<input type="checkbox"/> \$36,581 - \$48,651	<input type="checkbox"/> \$48,652 - \$60,723	<input type="checkbox"/> \$60,724 - \$73,160	<input type="checkbox"/> \$73,161 or more
6 <input type="checkbox"/> \$ 0 - \$41,960	<input type="checkbox"/> \$41,961 - \$55,807	<input type="checkbox"/> \$55,808 - \$69,654	<input type="checkbox"/> \$69,655 - \$83,920	<input type="checkbox"/> \$83,921 or more
7 <input type="checkbox"/> \$ 0 - \$47,340	<input type="checkbox"/> \$47,341 - \$62,962	<input type="checkbox"/> \$62,963 - \$78,584	<input type="checkbox"/> \$78,585 - \$94,680	<input type="checkbox"/> \$94,680 or more
8 <input type="checkbox"/> \$ 0 - \$52,720	<input type="checkbox"/> \$52,721 - \$70,118	<input type="checkbox"/> \$70,119 - \$87,515	<input type="checkbox"/> \$87,516 - \$105,440	<input type="checkbox"/> \$105,441 or more
<input type="checkbox"/> More than 8 people in the household (RHG staff will assist with scale calculation). <input type="checkbox"/> I do not wish to disclose my household income.				

Certification

By signing this I certify the following:

- Rural Health Group's *Sliding Fee Discount Program* has been explained to me.
- I have been offered an opportunity to apply for the discount program.
- If I am ineligible for the program *or* do not wish to apply at this time, I understand that I can be reassessed for the program if my income or household size changes *or* I decide to complete the application process by providing my household size and proof of income.

_____/_____/_____
 Signature Date

(Patient or legal guardian/closest relative/authorized representative, if the patient cannot sign)

FOR OFFICE USE ONLY	
Annual Income: \$ _____	Family Size _____
<input type="checkbox"/> Meets guidelines for Scale <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="checkbox"/> Does not meet guidelines (E) <input type="checkbox"/> Did not disclose
Sliding Fee Application: <input type="checkbox"/> Conditionally Approved – 30 Day (Need POI) <input type="checkbox"/> Application offered, patient does not wish to apply at this time	
RHG Staff (Printed Name & Signature): _____	Date: _____