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: ☐ Living in my own home/apartment (own or rent) ☐ Living with relatives/friends ☐ Experiencing Homelessness ☐ Shelter/Transitional housing	Are you a veteran? ☐ Yes ☐ No

Do you have medical insurance? ☐Yes ☐No

Health Insurance Name: _____

(If you have insurance, we will bill your insurance and apply the discount to any balance due for co-pays and deductibles.)

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	☐ $ 0 - $15,650	☐ $15,651 - $20,815	☐ $20,816 - $25,979	☐ $25,980 - $31,300	☐ $31,301 or more
2	☐ $ 0 - $21,150	☐ $21,151 - $28,130	☐ $28,131 - $35,109	☐ $35,110 - $42,300	☐ $42,301 or more
3	☐ $ 0 - $26,650	☐ $26,651 - $35,445	☐ $35,446 - $44,239	☐ $44,240 - $53,300	☐ $53,301 or more
4	☐ $ 0 - $32,150	☐ $32,151 - $42,760	☐ $42,761 - $53,369	☐ $53,370 - $64,300	☐ $64,301 or more
5	☐ $ 0 - $37,650	☐ $37,651 - $50,075	☐ $50,076 - $62,499	☐ $62,500 - $75,300	☐ $75,301 or more
6	☐ $ 0 - $43,150	☐ $43,151 - $57,390	☐ $57,391 - $71,629	☐ $71,630 - $86,300	☐ $86,301 or more
7	☐ $ 0 - $48,650	☐ $48,651 - $64,705	☐ $64,706 - $80,759	☐ $80,760 - $97,300	☐ $97,301 or more
8	☐ $ 0 - $54,150	☐ $54,151 - $72,020	☐ $72,021 - $89,889	☐ $89,890 - $108,300	☐ $108,301 or more

☐ More than 8 people in the household (*RHG staff will assist with scale calculation).*

☐ 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 _____

☐Meets guidelines for Scale ☐**A** ☐**B** ☐**C** ☐**D** ☐Does not meet guidelines (**E**) ☐Did not disclose

Sliding Fee Application: ☐ Conditionally Approved – 30 Day (Need POI) ☐ Application offered, patient does not wish to apply at this time

RHG Staff *(Printed Name & Signature)*: _____ Date: _____

Rev. January 2025