Confidential Financial Statement

Today's Date:_______________________________________

Patient Name: _______________________________________ **Date of Birth:** _________________________

Address: _______________________________________ **Phone Number:** _________________________

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Please complete the following statements as accurately and completely as possible. White House Clinics reserves the right to withdraw discounts for failure to provide correct information. It is your responsibility to inform us immediately of any change in income and/or insurance status.

White House Clinics is required by the Bureau of Primary Healthcare to obtain proof of income from patients annually. We use the proof of income, along with the information gathered on this form, to determine the amount we can discount the fees charged to you and your family. **WE CANNOT PROVIDE A DISCOUNT WITHOUT THIS INFORMATION. Today's visit will be discounted based on the information provided below. If you do not have documentation for today's visit, you will be considered self-pay until verification of your income is received [must be received by next visit or 30 days (whichever comes first)] and responsible for the cost of all services provided. (Initial)_______**

The information contained on this form is protected under HIPAA legislation. It will be used only for the purposes of determining the level of discount provided and to enroll you in Pharmaceutical Patient Assistance Programs. Your signature at the conclusion of this form indicates your consent for the sharing of this information with necessary pharmaceutical companies.

Please list all members residing in your household (including patient).

	Name	Date of Birth	Social Security #
1.			
2.			
3.			
4.			
5.			
6.			

Does the patient have any health insurance? _______ **Yes** _______ **No**

Does the patient have any dental insurance? _______ **Yes** _______ **No**

Do you have a prescription card? _______ **Yes** _______ **No**

How many members in the household work? ____________________

Does anyone in the household receive money from the following:

1. Wages from Employment	_______ Yes	_______ No	10. Retirement	_______ Yes	_______ No
2. Self-Employment Wages	_______ Yes	_______ No	11. Black Lung	_______ Yes	_______ No
3. Social Security Checks	_______ Yes	_______ No	12. Alimony	_______ Yes	_______ No
4. Disability Checks	_______ Yes	_______ No	13. Child Support	_______ Yes	_______ No
5. Farming Income	_______ Yes	_______ No	14. Military Wages	_______ Yes	_______ No
6. SSI	_______ Yes	_______ No	15. Unemployment	_______ Yes	_______ No
7. V.A. Pension	_______ Yes	_______ No	16. Rental Property	_______ Yes	_______ No
8. Interest Income	_______ Yes	_______ No	17. Worker's Comp.	_______ Yes	_______ No
9. Food Stamps	_______ Yes	_______ No			

If your household has no income, who pays your monthly bills? ______________________________

In order to receive the Sliding Fee Discount at White House Clinics, you must return the White House Clinics' Sliding Fee Authorization form. Each member of your household (18 years of age and older) must sign the White House Clinics' Sliding Fee Authorization form. This form will also be used to determine eligibility for Pharmaceutical Prescription Assistance Programs. (Patient's Initials) _____________

______________________________ ______________________

Signature of Interviewer/WHC Employee Date

FOR CLINIC USE ONLY (To Be Completed by Interviewer)

Income Source	Name	Amount on Document				Yearly Income
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	
			X		=	

Total Yearly Income: _____________

Sliding Fee Level Approved: ___________ Expiration Date: ____________

Facility: BPCC_____ WHC-Berea_____ WHC-Irvine_____ WHC-McKee_____
WHC-Mt. Vernon_____ WHC-Richmond_____ WHC-Paint Lick_____

Patient's eligibility for Medicaid has been verified on the Kentucky Medicaid website: Yes No

Signed: ____ Date: ___________________________________

WHITE HOUSE
CLINICS

White House Clinics' Sliding Fee Authorization Form

My signature below enrolls me in White House Clinics' Sliding Fee Discount Program, so long as I provide all necessary proof of income verification for all household members.

My signature authorizes White House Clinics to share my financial information with Pharmaceutical Prescription Assistance Programs so that I may have access to those medications available from various drug companies.

Each member of your household (18 years of age and older) must sign and date the White House Clinics' Sliding Fee Authorization form.

Name	Signature	Date
____________	____________	______

Name | **Signature** | **Date**

Name | **Signature** | **Date**

Name | **Signature** | **Date**

Name | **Signature** | **Date**

Name | **Signature** | **Date**

Name | **Signature** | **Date**