



**FAMILY INCOME**

**IMPORTANT**

**We are pleased to inform you that you may be eligible for a discount on your medical or dental services today based on your income.**

**Why do we collect this information?** It is difficult for many families to pay for health care due to their income. CHESI is provided grant funding by the Bureau of Primary Health Care to try to assist these families cover expenses incurred when they receive treatment at one of our facilities. However, in order to do this, we must report the income levels of the families we serve to them. We provide this information in a summary form...individual income is NOT reported. Please help us to continue receiving these grant dollars by completing the following questions:

If you circled an income range in columns AB, CD, EF, GH or column IJ, and do not have any form of insurance, you may qualify for discounted medical and dental services for today’s charges. Please complete the other side of this form.

1. Please tell us about your **HOUSEHOLD** Income. Find the *Household Size* in the column on the left, then go across that line and circle your household gross (before taxes/deductions) *income range* in the same line.

Family Size	0% A-B (20%)	20% C-D	40% E-F	60% G-H	80% I-J	100% K
1	10,830	10831 - 13538	13539 - 16245	16246 - 18953	18954 - 21659	21660
2	14,570	14571 - 18213	18214 - 21855	21856 - 25498	25499 - 29139	29140
3	18,310	18311 - 22888	22889 - 27465	27466 - 32043	32044 - 36619	36620
4	22,050	22051 - 27563	27564 - 33075	33076 - 38588	38589 - 44099	44100
5	25,790	25791 - 32238	32239 - 38685	38686 - 45133	45134 - 51579	51580
6	29,530	29531 - 36913	36914 - 44295	44296 - 51678	51679 - 59059	59060
7	33,270	33271 - 41588	41589 - 49905	49906 - 58223	58224 - 66539	66540
8	37,010	37011 - 46263	46264 - 55515	55516 - 64768	64769 - 74019	74020

Each additional family member, add \$3740.

**If you circled an income in range in column K, we thank you for taking the time to complete this form. Please give this paper to the receptionist.**



Community Health & Emergency Services Inc.

Dear Patient:

We are pleased to be able to allow you a discount for your medical services because we believe it is essential that health care be affordable. To insure that we can offer this service to every client, we must make sure that someone not eligible, who can afford the services, is not receiving a fraudulent discount.

With this in mind, we are asking you to fill out and sign the application below.

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ AGE: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF DEPENDENT CHILDREN AND SPOUSE LIVING IN THE HOME:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SLIDING FEE:

\_\_\_\_\_ MEDICAL \_\_\_\_\_ DENTAL \_\_\_\_\_ PODIATRY \_\_\_\_\_ OPTOMETRY

REFERRING PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_\_

INCOME: Jobs, social security, child support, SSI, interest on bank accounts, pensions, retirement funds, veteran funds, public aid, general assistance, rentals or employment.

WEEKLY \_\_\_\_\_ MONTHLY \_\_\_\_\_ ANNUAL \_\_\_\_\_  
x52 \_\_\_\_\_ x12 \_\_\_\_\_

ANY ADDITIONAL INCOME OF ANY KIND: \_\_\_\_\_

TOTAL INCOME: \_\_\_\_\_ VERIFIED BY: \_\_\_\_\_ PHONE CALL \_\_\_\_\_ LETTER \_\_\_\_\_  
WAGE STUB \_\_\_\_\_ COPY OF CHECK \_\_\_\_\_  
IRS FORM \_\_\_\_\_ OTHER \_\_\_\_\_

\_\_\_\_\_  
(DATE) (SIGNATURE OF AUTHORIZED STAFF MEMBER)

NUMBER OF DEPENDENTS ON ABOVE INCOME: \_\_\_\_\_

The above information is true and correct. I understand I am paying the minimal fee or the discounted \_\_\_\_\_% of my bill. I will report any income changes to Community Health & Emergency Services, Inc.

I understand that verification of income should be presented prior to my next visit or within ten (10) days, whichever date is first.

\_\_\_\_\_  
(DATE) (PATIENT SIGNATURE)

\_\_\_\_\_  
(WITNESS)

**For Agency Use Only**

\_\_\_\_\_ *Card Issued* \_\_\_\_\_ *Date Verified* \_\_\_\_\_ *% Medical*  
\_\_\_\_\_ *Need Verification* \_\_\_\_\_ *Number in Household* \_\_\_\_\_ *% Dental*  
\_\_\_\_\_ *Denied/Not Eligible*