HOUSEHOLD ASSESSMENT

IMPORTANT! This form must be completed fully. If you qualify for the Sliding Fee Scale Program, it will apply to every member of your household that is listed below. For additional family members, use a second form.

HEAD OF HOUSEHOLD PERSONAL INFORMATION:
First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____ E-mail Address: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: ____/____/_____ Social Security #: _____ Are you married? ☐ Yes ☐ No

Last name, First name	Relationship to Responsible Party	Date of Birth	Name of Health Insurance Company	Employer Name	Patient at Clinic
	SELF	/ /			Y or N
		/ /			Y or N
		/ /			Y or N
		/ /			Y or N
		/ /			Y or N

What is your current housing situation?

☐ I have a home (own or rent/lease apartment or house)
☐ I do not have a home, I stay at:
- ☐ Shelter
- ☐ Street
- ☐ Doubling Up/Couch-Surfing
- ☐ Transitional/Halfway House
- ☐ Other: _____

Are you a full-time student?
☐ Yes ☐ No

ITEMS ACCEPTED AS FORMS OF INCOME VERIFICATION
(Check all being submitted)

- ☐ Income tax form from previous year.
- ☐ Statement from social security/disability.
- ☐ One month's worth of pay stubs.
- ☐ Notice of Action from food support, TANF, etc.
- ☐ Student schedule for current semester.
- ☐ Documentation pertaining to child support, TANF, etc.
- ☐ Note on letterhead from an organization assisting patient with their financial status.
- ☐ If unemployed within the last month, documentation of income earned prior to loss of employment.

If you are unable to prove income, please contact the billing office.

Sliding Fee
The Sliding Fee Scale Program is based on household size and gross income. Verification of income is mandatory. By signing below, I agree that FCH may contact each employer of all persons working in the above-mentioned household and/or may contact various agencies to verify any source of income. I will be asked to reapply for the Sliding Fee Scale Program at least once a year. I am obligated to inform FCH of any changes in household size, income, and/or insurance. Applicants lacking required information will be denied without notice after 30 days.

I verify that all information provided on this form is true and correct.

Authorization:

_____ _____ _____
Signature of Patient or Authorized Agent | Print Name | Date

☐ Check here if submitting additional forms.

_____
Relationship to Patient (if patient not signing)