



INCOME WORKSHEET
FARGO CASS PUBLIC HEALTH
FAMILY PLANNING PROGRAM

There are charges for the services provided for you. These charges may be discounted based on your income and family size. Payment is requested at the time of your visit; however, if payment cannot be made in full, we ask that you make arrangements for payment of any unpaid balance.

Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Address			City		State ZIP Code
Marital Status	Years of Education Completed	Email Address			Home or Cell Telephone Number () -
Occupation		Name of Employer			Work Telephone Number () -
Race - Check all that apply <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown					
Ethnicity - Check at least one <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not Hispanic Origin <input type="checkbox"/> Unknown/Not Reported					
If we need to contact you, may we call or send mail to the above address? <input type="checkbox"/> Yes <input type="checkbox"/> No			Best Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If no, how may we contact you?
In Case of Emergency, Contact:			Relationship		Telephone Number

GROSS INCOME (before taxes)

Self

Wages per Hour	X	Hours Per Week	=	Total (Gross)

Other Household Income (include spouse/partner)

Wages per Hour	X	Hours Per Week	=	Total (Gross)

Other Household Income (child support, social security, tips, and unemployment)

Monthly Total (Gross)

If the patient is under 19 years of age, please mark the correct boxes for VFC (Vaccine for Children) eligibility

Native American
 Medicaid Eligible MA # _____
 No Insurance
 Underinsured (Vaccines not covered by health insurance)
 Insured (Vaccines covered by insurance – not VFC eligible)

Total Number of Household Members (including yourself) Depending on This Income	Total Gross Income

Do you receive medical assistance/Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes	ID Number	Do you have health insurance <input type="checkbox"/> No <input type="checkbox"/> Yes-If you want us to file the claim, complete the following:		
Name of Insurance Company		Contract Number		
Address		City	State	Zip Code
Name of Policy Holder		Date of Birth	Relationship to Policy Holder	

_____ (Please initial). I authorize the release of any medical information necessary to process an insurance claim and payment of medical insurance benefits.

Tobacco Use (client) Yes No

The answers to the above questions are true and complete to the best of my knowledge

Client Signature			Date
Chart Number	Total Gross Income	Income Code	Staff Initials
		/ %	

DONATIONS ARE APPRECIATED