Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Income Certification Form

Chart No:_____

It is necessary for us to ask personal questions in order to determine if you qualify for a discount for your visits. If you choose to not complete this documentation you will not be eligible to receive any discount. This information is confidential and will be kept in your medical record.

Patient Name: _____ Date of Birth: _____

1. Medical Insurance: I receive coverage from the following type of insurance:

- ☐ Medicare
- ☐ Medi-Cal / CalOptima
- ☐ I am not currently receiving any insurance coverage.
- ☐ Blue Shield PPO
- ☐ Molina Health Care of California HMO
- ☐ Private Insurance

2. Family Income: My family receives $_____ for each:

☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Bi-Monthly (24) ☐ Monthly (12) ☐ Yearly (1)

If no income:

☐ My family has no wages or income. I am not working (receiving salary or wages for work), or receiving unemployment or disability benefits. My income is $0.

3. Family Size: The number of family members in my household is: _____

By signing below I certify that the above information is true and accurate and that I have reported all income. I acknowledge that I will be asked to verify my income on an annual basis and will provide proof of income if requested.

Signature of patient or legal guardian: _____ Date: _____

FOR STAFF USE ONLY:

Calculate: $_____ (family income) X _____ (per year) = $ _____ (annual income)

Enter annual income to calculate Sliding Fee Payment Amount: $ _____ per visit.

Comments:

_____

_____

_____

_____

Additional income documentation provided:

- ☐ Check Stubs
- ☐ Tax Forms (W2, Disability, SSI)
- ☐ Bank Statement
- ☐ Other: _____

☐ **PATIENT REFUSED TO SIGN CERTIFICATION OF INCOME FORM**

Staff Signature: _____ Date: _____