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: _____

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

Certificación de Ingresos

Chart No:_____

Es necesario hacer preguntas personales para poder determinar si usted califica para obtener descuentos en sus visitas médicas. Si usted elige no completar esta forma no será elegible para obtener un descuento. Esta información es confidencial y será mantenida en su archivo médico.

Nombre del Paciente: _____ Fecha de Nacimiento: _____

1. Seguros Médicos: Yo recibo beneficios médicos de los siguientes seguros médicos:

☐ Medicare ☐ Blue Shield PPO
☐ Medi-Cal / CalOptima ☐ Molina Health Care of California HMO
☐ No estoy recibiendo ningún beneficio médico. ☐ Seguro Médico Privado

2. Ingresos de la Familia: Mi familia recibe $_____ por cada:

☐ Semanal (52) ☐ Quincenal (26) ☐ Dos Veces Por Mes (24) ☐ Mensual (12) ☐ Anual (1)

Si no tiene ingresos:

☐ Mi familia no recibe salarios ni ingresos. No estoy trabajando, o recibiendo beneficios del seguro de desempleo o seguro de incapacidad. Mis ingresos son $0.

3. Tamaño Familiar: Miembros en la familia: _____

Al firmar abajo yo certifico que la información de arriba es precisa y correcta y que he reportado todos mis ingresos. Yo reconozco que seré requerido a verificar mis ingresos anualmente y proveeré verificación de ingresos cuando sea requerido.

Firma del paciente o guardián legal: _____ Fecha: _____

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 Initials: _____ Date: _____