Camino Health Center

Income Certification Form

Chart No: _____

Please answer all questions to the best of your ability. Your answers are confidential. Camino Health Center utilizes this information to determine if you qualify for a discount for your care. Not completing this documentation will make you ineligible to receive any discounts. This form is important to your health because it lets Camino be certain that you are receiving the very best service regardless of your income, family size, or insurance status.

Patient Name: _____ **Date of Birth** _____

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

- ☐ Medicare
- ☐ Medi-Cal / CalOptima
- ☐ Covered California - Blue Shield PPO
- ☐ I am currently not receiving any insurance coverage

Insurance Policy I.D. _____

2. Family Income: My family receives $ _____ every:

- ☐ Week (52)
- ☐ Two Weeks (26)
- ☐ Month (12)
- ☐ Year (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:** _____