Washington County Public Health
Client Financial Information

Name_____ Date _____

☐Initial ☐Annual ☐Pay Source Change

☐ Medicare #_____ ☐ Veteranôs Administration (SSN) _____
☐ Medicaid (Title XIX)_____ ☐ Private Pay (full fee)
☐ State Grant ï sliding fee determined below ☐ other

Services provided: ☐ Skilled Nursing ☐ Home Care Aide ☐ Homemaker ☐ Other _____

In order to determine fee status in a non-discriminatory manner, the following financial information is needed. If you are unwilling to provide this information, you will be charged the full fee for services provided.

I do not wish to disclose my income/resources and agree to pay full fee for services not covered by a 3rd party payor.
Client Signature_____ **Date**_____

Monthly Household Income:		**Monthly Medical Expenses:**		**Unrestricted Assets:**	
Earnings/Salary		Prescription Medication		Cert. of Deposits	
Social Security		Medical Bills		Stocks/Bonds/CDôs	
Disability		Insurance Premiums		Savings Account	
Pension		Medical Supplies		Checking Account	
Income from farmland or other property		Lifeline		Other	
Other Income:		Durable Medical Equipment			
Interest from:		Other: _____			
Cert. of Deposit		**Total Expenses:**		**Total Resources:**	
Stocks & Bonds					
Other:_____		FOR OFFICE USE ONLY			
Total Income:		**Adjusted Income (Income–Expenses)**			
		Resources			
		Amount used to calculate sliding fee			

Total Number in household _____

I verify that the financial information above is correct to the best of my knowledge. WCPH reserves the right to request supporting documents (receipts, bank statements, etc.) to support the financial statement.

Client Signature _____ **Date**_____

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Service Charge			**Fee**	**Comments**
Skilled Nursing	=	$ 130.00	$ _____ per visit	
Home Care Aide	=	$ 45.00	$ _____ per hour	
Homemaker	=	$ 30.00	$ _____ per hour	
Other	=	$ _____	$ _____ per visit	

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Instructions for completing Financial Information Form

1. **Monthly household income**:
    a. **Earnings/Salary**: Calculate monthly salary/earnings of client and spouse (if applicable).
    b. **Social Security**: monthly net income after deductions (Medicare premium)
    c. **Disability** ï SSI or any other form of disability income (i.e. Aflac, short-term, long-term disability)
    d. **Pension**: Income from ---see restricted assets from Chapter 80, VA pension, IPERS, Railroad pension, fixed sum paid regularly to a person
    e. **Income from farmland or other property**
    f. **Other income**: income that does not fall under one of the above categories
    g. **Interest from**: money received from interest bearing accounts that would not be considered Restricted Assets (Cert. of Deposits, Stocks & Bonds, etc.
    h. **Total Income**: Sum of all monthly household income sources

2. **Monthly Medical Expenses**: Actual out of pocket medical expenses not covered by any third party payor. This could include prescription co-pays, medical/insurance deductibles, regular payments toward medical care not covered by third party payor, premiums for primary or supplemental health insurance, medical supplies necessary for treatment or care that are not covered by a third party payor, lifeline expenses, or durable medical equipment. Other medical costs may include hearing aides, eye glasses, dentures, etc.
    a. Total expenses: Sum of all monthly household medical expenses.

3. **Unrestricted Assets:** List the amount of Certificate of Deposits, Stocks/Bonds/CDôs, Savings Accounts, Checking Account, and any other assets you currently have in this section.

4. **Total number in Household**: List total number of people living in household.