Health Help, Inc.

Confidential Financial Statement

Today's Date________________

Patient Name: ____________________________ **Date of Birth:** ________________

Address: ________________________________ **Phone Number:** ______________

Health Help, Inc. is required by the Bureau of Primary Healthcare to obtain proof of income from patients annually. We use the proof of income, along with the information gathered on this form, to determine the amount we can discount the fees charged to you and your family. **WE CANNOT PROVIDE A DISCOUNT WITHOUT THIS INFORMATION. It will be necessary for you to provide verification of income before your next visit at a Health Help, Inc. facility. Failure to provide proof of income prior to next visit will result in a full charge for the visit.**_____________

Please complete the following statements as accurately and completely as possible. Health Help, Inc. reserves the right to withdraw discounts for failure to provide correct information.

This information contained on this form will be kept confidential and will be used only for the purpose of determining the level of discount provided to the patient.

Please list all members residing in your household (including patient).

	Name	Date of Birth
1.		
2.		
3.		
4.		
5.		
6.		

Does the patient have any health insurance? ______ **Yes** ______ **No**

Does the patient have any dental insurance? ______ **Yes** ______ **No**

Do you have a prescription card? ______ **Yes** ______ **No**

How many members in the household work? ________________________

Does anyone in the house receive foodstamps? ______ **Yes** ______ **No**

If yes, what is the total monthly amount? ___________________________

Does anyone in the household receive money from the following:

#	Source	Yes	No	Name & Amount
1.	Wages from Employment	______ Yes	______ No	__________________
2.	Self-Employment Wages	______ Yes	______ No	__________________
3.	Social Security Checks	______ Yes	______ No	__________________
4.	Disability Checks	______ Yes	______ No	__________________
5.	Farming Income	______ Yes	______ No	__________________
6.	SSI	______ Yes	______ No	__________________
7.	V.A. Pension	______ Yes	______ No	__________________
8.	Interest Income	______ Yes	______ No	__________________
9.	Retirement Checks	______ Yes	______ No	__________________
10.	Black Lung Payments	______ Yes	______ No	__________________
11.	Alimony/Child Support	______ Yes	______ No	__________________
12.	Military Wages	______ Yes	______ No	__________________
13.	Unemployment Checks	______ Yes	______ No	__________________
14.	Rental Property Income	______ Yes	______ No	__________________
15.	Workman's Compensation	______ Yes	______ No	__________________

If your household has no income, who pays your monthly bills? _______________

Your signature below indicates your affirm that the statements above are true and provide your consent for further verification of the facts as needed by a Health Help, Inc. facility.

________________________________ ________________________________

Signature & Date of Patient **Signature & Date of Interviewer**

FOR CLINIC USE ONLY (To Be Completed by Interviewer)

Total Household Income: _________________**/Month** _________________**/Year**

Sliding Fee Level Approved: _______________ **Expiration Date:** ________

Facility: ______ **WHC – McKee** ______ **WHC – Berea** ______ **BPCC**