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**Lake Region Family Planning**

**Income Work Sheet**

Created: April 2024

**Legal** Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex Assigned at Birth Female Male

 (Optional) Name you prefer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Main Language:  English  Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

**We may need to contact you with positive test results or billing/insurance questions.**

 **Contact Information**

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave detailed voicemail messages? Yes No

 OK to send detailed text messages? Yes No

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to email if we cannot reach you by phone? Yes No

OK to mail you at above address?  Yes  No

Alternative address for billing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nicotine Status:  Current Everyday Use  Current Some Day Use  Former  Never**

Are you Hispanic, Latino, or Spanish origin? Yes No

Race (check all that apply):

 Asian Black Native American/Alaskan Native Pacific Islander/Hawaiian White Decline to Specify

 N

**EMERGENCY CONTACT**  (If you have an emergency today)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

 🞏 Medicaid (traditional)  🞏 Private Health Insurance (Sanford, Blue Cross, United, etc.) 🞏 Medicaid (expansion) 🞏 *Women’s Way*

🞏 None/uninsured 🞏 Government Insurance (Military, VA)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Primary Insurance | Policy Number | Name of Policy Holder | Policy Holder Date of Birth |
| Name Secondary Insurance | Policy Number | Name of Policy Holder | Policy Holder Date of Birth |
| May we submit to insurance?  Yes  No Are you requesting confidential services  Yes  No |

I understand: \*Medicaid documents containing visit details will NOT be mailed to my home.

 \*Private insurance companies will send visit details/EOB to your home unless you are

 Over age 18 and request them to be sent to an alternative location.

 (\*\*\*\*Explanation of Benefits (EOB) are notifications that insurance companies send that includes payment and visit details\*\*\*\*)

Initial Here



\*\*\***To opt out** of discount services, skip this section

 and provide signature in the blue box below.

**Household Size and Income Information:**

**Household Size:** \_\_\_\_\_\_\_\_\_\_

\*\*\*If under the age of 18 and requesting confidential service, *only report your own income*.

**Your Yearly Income before Tax:**

  Job #1\_\_\_\_\_\_\_\_ hours weekly at $\_\_\_\_\_\_\_\_\_\_ /per hour = $ \_\_\_\_\_\_\_\_\_\_\_\_\_

$ .00

 Job #2 \_\_\_\_\_\_\_\_hours weekly at $\_\_\_\_\_\_\_\_\_\_ /per hour = $ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Partner/Spouse Yealy Income:** (include roommates)

  Job #1\_\_\_\_\_\_\_\_hours weekly at $\_\_\_\_\_\_\_\_\_\_ /per hour = $ \_\_\_\_\_\_\_\_\_\_\_\_\_

$ .00

 Job #2\_\_\_\_\_\_\_\_ hours weekly at $\_\_\_\_\_\_\_\_\_\_ /per hour = $ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Income or Financial Support**

$\_\_\_\_\_\_\_\_\_\_\_\_\_ per week

$\_\_\_\_\_\_\_\_\_\_\_\_\_ per month

$\_\_\_\_\_\_\_\_\_\_\_\_\_ per month

$\_\_\_\_\_\_\_\_\_\_\_\_\_ per month

$\_\_\_\_\_\_\_\_\_\_\_\_\_ per month

$\_\_\_\_\_\_\_\_\_\_\_\_\_ per month

Tips or Commission

Regular Family Support (support by someone not living in the household)

Grants or Stipends (the amounts used towards living expenses)

Unemployment

Alimony

Income from an owned rental property (NOT amount paid for rent)

**Total Household Income $\_\_\_\_\_\_\_\_\_\_\_\_\_.00**

**TO OPT-OUT OF DISCOUNTS** – REVIEW AND SIGN THE STATEMENT BELOW:

**I would not like to disclose my household size and/or income information. I understand** **that by choosing to opt-out I will not be eligible for discounts on my services today, and I will be charged at the full fee. I understand that after I leave the clinic, I cannot apply for discounts for services that have already been provided.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_**

**FINANCIAL RESPONSIBILITY CONSENT**

I voluntarily request services from Lake Region Family Planning (LRFP) and accept full financial responsibility for any costs after insurance and applicable discounts. I understand that I may set up a payment plan. Amounts with no payments for over 90 days may be released to an outside collection agency, unless services were for a minor requesting confidential status. Essential services will not be denied for inability to pay. If providing insurance, I authorize LRFP to release any information necessary to process my claims to be paid directly to LRFP. I have had the opportunity to review my plan benefits prior to services and choose an in-network provider for optimal coverage.

 **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date \_\_\_\_\_\_\_\_\_\_**

**For Staff Use Only:**

Household Size

Total Monthly Income

Discount Scale

0% 25% 50% 75% 100%

Staff Initials