**Patient Income Eligibility Form**

**Patient Name/***Nombre del paciente:* **Acct #:**

**Gulf Coast Health Center, Inc. offers a sliding fee scale discount to those patients who properly qualify. A patient does not have to be uninsured to qualify for a discount. If you feel you may qualify for a sliding fee scale discount, please complete the information below and submit any applicable household income documentation:**

*Gulf Coast Health Center ofrece una escala de descuento a los pacientes que califiquen apropiadamente. Si un paciente tiene seguro medico aun puede aplicar y calificar para recibir el descuento. Si uste cree que quiza puede calificar para el descuento, favor de presenter cualquiera de los siguientes documentos:*

* **Current year income tax (complete 1040 & all schedules) /** *El ingreso anual de la casa (forma 1040)*
* **Current year check stub (within the last 30 days)** *Talon de cheque mas reciente (los ultimos 30 dias)*
* **Current year Social Security award letter**. *Carta del seguro social mas reciente*.
* **Copy of current year check from social security or retirement. /** *Cheque del seguro social o Jubilacion.*
* **Food stamp award letter with dollar amount**

*Carta de estapillas con la cantidad que recibe al mes.*

* **Current unemployment statement or check stub** *Carta de desempleo mas reciente con la cantidad que recibe por semana.*
* **Current Child Support check stub /**

*Carta de pension alimenticia con la cantidad que recibe al mes.*

* **Notarized letter of support with the person signing current income information /** Una c*arta notarizada de la persona que le ayuda economicamente, junto con la prueba de ingreso de esa persona.*
* **Notarized letter of cash payments form patient’s employer on company letterhead./** *carta notarizada de su empleador si le pagan en efectivo o una carta membretada con el nombre de la compania donde trabaja.*
* **Copy of bank statement showing direct deposits./** *Una copia del estado de cuenta bancario donde muestre los depositos directos.*

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| --- | --- | --- |
| **How many people currently live in your residence (Household)?***Actualmente cuantas personas viven en su casa.*  |  | **Please list their information below:***Porfavor indique la siguente informacion***.** |
| **Family Members’ Name***Miembros de la familia* | **Relationship***Relacion* | **Date of Birth***Fecha de nacimiento* | **SSN***Numero de seguro social* | **Annual Income***Ingreso anual* |
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|  |  |  |  |  |
| **Who is your current employer?***Quien es su empleador actual?* | **What is your current salary/wage/income amount?***Cual es su salario actual?* |

***\*\*For Administrative Use Only\*\****

Use the following formula to calculate household income when patient provides **check stub**: (i.e. $10,000/100 days=100, 100\*365 days=$36,500 total income)

YTD **Gross Income** **$** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **÷** Number of **Days Employed** \_\_\_\_\_\_\_\_\_\_\_ **=** \_\_\_\_\_\_\_\_\_\_ **X** 365 Days **=**  \***Total Income $\_\_\_\_\_\_\_\_\_\_\_\_\_**

(\**If presented with* ***Income Tax*** *Enter Adjusted gross income amount. No formula needed.)*

*Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clerk Initials: \_\_\_\_\_\_\_\_\_\_\_*

 **Income Expires: Sliding Fee:**

***Use the following Income Tax guidelines to determine income eligibility:***

**Form 1040 Tax Return**

1. Use line #37 **Adjusted Gross Income**
2. Add in line # 20a ( Social Security benefits)

 **Form 1040EZ Tax Return**

1. Use line # 4 **Adjusted Gross Income**

**Form 1040A Tax Return**

1. Use line #21 **Adjusted Gross Income**
2. Add in line # 14a (Social Security benefits