



Statement of Income

As a Federally Qualified Health Center, Boston Mountain, is required to collect income information on all patients even if you choose not to participate in the Sliding Fee Scale Program. Please choose your household gross annual income range:

<input type="checkbox"/> \$0 - \$11,880	<input type="checkbox"/> \$11,881 - \$23,881	<input type="checkbox"/> \$23,882 - \$34,882
<input type="checkbox"/> \$34,883 - \$45,883	<input type="checkbox"/> \$45,884 - \$56,884	<input type="checkbox"/> \$56,885 - \$67,885
<input type="checkbox"/> \$67,886 - \$77,886	<input type="checkbox"/> \$77,887 - \$88,887	<input type="checkbox"/> \$88,888 - \$99,888
<input type="checkbox"/> \$99,889 - \$110,889	<input type="checkbox"/> \$110,890 - Above	<input type="checkbox"/> Choose not to disclose

****Please ask the receptionist for more information on the Sliding Fee Scale Program***

Number of Household Members (Including Self): _____

Patient OR Parent/Guardian Signature

Date

Internal Notes:

Select Annual Income, Enter Number of Dependents, If patient elects to not bring in income verification, Select Box None Proof of Income (Patient will be set at 100% responsibility level), and then mark Assign. Also, expire the slide until the end of year. **DO NOT SET FEE SCHEDULE AT SLIDE UNLESS PROOF OF INCOME IS PRESENTED. (You may use this current form for the entire family for the year).**

If patient choosing not to disclose, go to additional information, structured and make the selection.