INCOME WORKSHEET
NORTH DAKOTA DEPARTMENT OF HEALTH
FAMILY PLANNING PROGRAM
SFN 8625 (Rev. 11-2016)

There are charges for the services provided for you. These charges may be discounted based on your income and family size. Payment is requested at the time of your visit; however, if payment cannot be made in full, we ask that you make arrangements for payment of any unpaid balance.

Name (First Middle Last)	**Former/Maiden Name**	**Gender**	**Date of Birth**

Address	**City**	**State**	**ZIP Code**

Cell Phone Number	**Home Phone Number**	**Work Phone Number**	**Student** ☐ Yes ☐ No	**Years of Education Completed**

Email Address	**Name of Employer**	**Primary Language** **English**

Marital Status (check one) ☐ Living Together ☐ Single ☐ Married ☐ Separated ☐ Divorced Widowed	**Are you Hispanic?** ☐ Yes ☐ No

Race: (check all that apply)
☐ White ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

Check all the ways we may contact you (by checking the box, you are giving consent) ☐ Call Cell ☐ Text Message (outgoing only) ☐ Email ☐ Call Home ☐ Call Work ☐ Mail ☐ Don't Contact	**Cell Carrier**

Okay to leave a message or voice mail at above-listed contact numbers?
☐ Yes ☐ No

Emergency Contact Information: Please tell us who to contact in case of emergency (trusted adult if under 18); An emergency would be severe bleeding, unconsciousness, accident or a condition requiring emergency intervention. **Family planning services DO NOT require parental permission**; however, in an emergency situation, if you are under 18 years of age, we will notify a trusted adult.

In Case of Emergency Contact:	**Your Relationship To**	**Telephone Number**

Do you use tobacco (to include e-cigarette, vaping, chew, pipe, cigarette)?
☐ Yes ☐ No

Do you receive medical assistance/ Medicaid? ☐ Yes ☐ No	**ID Number**	**Do you have health insurance? ☐ Yes ☐ No**	**May we submit to insurance? ☐ Yes ☐ No**

Name of Insurance Company	**Contract Number**

Address	**City**	**State**	**ZIP Code**

Name of Policyholder	**Date of Birth**	**Your Relationship to Policy Holder**

If you are 17 years old or younger and covered under your parents' or guardians' insurance plan:
You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder (your parents or guardians) about the health care services you receive at the clinic.

If you are 18 years old or older and have private insurance coverage and are not the policy holder:
You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder about the health care services you receive at the clinic. You may contact your insurance company to request that EOBs be sent to you instead of the policy holder to protect your privacy.

Client Signature	**Date**

FOR OFFICE USE ONLY

Is client requesting confidential services? ☐ Yes ☐ No	**Patient Number**	**Total Gross Income**	**Income Code** **/ %**	**Staff Initials**

Services are based on a sliding scale according to your income, please report below (as applicable):

A. SELF (this is your income BEFORE taxes)

Wage per Hour	**X**	**Hours/Week**	**=**	**Weekly Total**	**X 52 Weeks =**	**Annual Gross Income**
OR				**Weekly Gross**	**X 52 Weeks =**	**Annual Gross Income**
OR				**Gross Every 2 Weeks**	**X 26 Weeks =**	**Annual Gross Income**
OR				**Monthly Gross**	**x 12 Months =**	**Annual Gross Income**

B. **OTHER HOUSEHOLD INCOME** (income from those people you live with: spouse, partner, parents)

Monthly Gross	**X 12 Months =**	**Annual Gross**

C. **OTHER INCOME** (social security, tips, unemployment)

Weekly Gross	**x 52 Weeks =**	**Annual Gross Income**

OR

Monthly Gross	**X 12 Months =**	**Annual Gross Income**

Total of all Annual Gross Incomes (A+B+C)
Total number of household members (including yourself) that depend on this income

The answers to the above questions are true and complete to the best of my knowledge.

Client Signature	**Date**
	Date of Birth
Patient Number	