



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



**Public Health**  
 Prevent. Promote. Protect.  
 Fargo Cass Public Health

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Years of Education Completed	
Email Address			Name of Employer			Primary Language	
Marital Status (check one) <i>Legally Separated</i> <input type="checkbox"/> Living Together <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced Widowed						Are you Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Not Hispanic or Latino</i>	
Race: <i>Caucasian (White), American Indian or Alaskan Native</i> <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian						(check all that apply)	
Check all the ways we may contact you (by checking the box, you are giving consent) <input type="checkbox"/> Call Cell <input type="checkbox"/> Text Message (outgoing only) <input type="checkbox"/> Email <input type="checkbox"/> Call Home <input type="checkbox"/> Call Work <input type="checkbox"/> Mail <input type="checkbox"/> Don't Contact						Cell Carrier	
Okay to leave a message or voice mail at above-listed contact numbers? <input type="checkbox"/> Yes <input type="checkbox"/> 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, and/or cigarette)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Do you receive medical assistance/Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		ID Number		Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we submit to insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
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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

Income verification / determination method: <input type="checkbox"/> Pay check <input type="checkbox"/> Tax return <input type="checkbox"/> Verbal <input type="checkbox"/> Other _____
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The answers to the above questions are true and complete to the best of my knowledge.

Client Signature	Date
	Date of Birth
Patient Number	

**FOR OFFICE USE ONLY**

Is client requesting confidential services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Number	Total Gross Income	Income Code / %	Staff Initials
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