BrevardHEALTHAlliance INCORPORATED

FINANCIAL DETERMINATION WORKSHEET

Patient Name : Patient Date of Birth *(mo/day/yr)*: / /

Insurance Information Do you currently have insurance? ☐ Yes ☐ No
Insurance Company: ______
Subscriber No.: ______ Group No.: ______
Policyholder's Name: ______ Birthdate: __/__/__ Policyholder's SSN: ___-___-___
Policyholder's mailing address: ______ City: ______ State: ______ Zip: ______
Phone: ______

<u>Please bring the following when coming in to register for the Sliding-Fee Scale:</u>

1. Picture ID – or other proof to confirm Brevard County residency.
2. Social Security Card – if possible.
3. Proof of gross monthly income – for the last 2 months for all related household members, such as:
   - Paycheck stubs
   - Social Security Income
   - Bank Statements
   - W2 Statements
4. Federal Income Tax Return – the patient's most recently filed Return is required to apply for assistance with medications.

HOUSEHOLD INCOME AMOUNT AND FREQUENCY	SOURCE OF HOUSEHOLD INCOME (check all that apply)
Hourly: $ ______ x 2080 = $ ______	☐ Employment $ ______/month
Weekly: $ ______ x 52 = $ ______	☐ AFDC $ ______/month
Monthly: $ ______ x 12 = $ ______	☐ Social Sec. $ ______/month
Other: $ ______ x = $ ______	☐ SSI $ ______/month
	☐ Child Support $ ______/month
	☐ Other $ ______/month

RESIDENCE: ☐ OWN ☐ RENT ☐ OTHER: ______

NUMBER OF RELATIVES IN HOUSEHOLD: ______

NAME: ______ AGE: ______ RELATIONSHIP: ______
NAME: ______ AGE: ______ RELATIONSHIP: ______
NAME: ______ AGE: ______ RELATIONSHIP: ______
NAME: ______ AGE: ______ RELATIONSHIP: ______

Proof of Income: ☐ YES ☐ NO (Please check all that apply)
☐ Tax Return ☐ Wage Statement ☐ SS Statement ☐ Bank Statement ☐ Other: ______

I, ______, have a household income of $______,
every ☐Week, ☐Month, ☐ Year, but attest that I am unable to provide proof of that income.

I attest that I have provided complete and accurate information regarding all of my household income and assets.

Patient or Parent/Guardian: ______ ______
Signature Date

Witness: ______ ______
Brevard Health Alliance Representative Date

*****Fees start at $10 for a Medical Visit on the Sliding-Fee Scale*****