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: _____

Please bring the following when coming in to register for the Sliding-Fee Scale:

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