Lake Region Family Planning
Income Work Sheet

Created: April 2024

Legal Full Name: _____ Sex Assigned at Birth ☐ Female ☐ Male

(Optional) Name you prefer: _____ Gender Identity_____ Pronouns_____

Date of Birth: _____ Age: _____ Main Language: ☐ English ☐ Other_____

Mailing Address _____ City _____ State _____ Zip _____

We may need to contact you with positive test results or billing/insurance questions.

Contact Information

Phone _____ OK to leave detailed voicemail messages? ☐ Yes ☐ No

OK to send detailed text messages? ☐ Yes ☐ No

Email _____ OK to email if we cannot reach you by phone? ☐ Yes ☐ No

OK to mail you at above address? ☐ Yes ☐ No

Alternative address for billing: _____

Nicotine Status: ☐ **Current Everyday Use** ☐ **Current Some Day Use** ☐ **Former** ☐ **Never**

Are you Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

Race (check all that apply):

☐ Asian ☐ Black ☐ Native American/Alaskan Native ☐ Pacific Islander/Hawaiian ☐ White ☐ Decline to Specify

EMERGENCY CONTACT (If you have an emergency today)

Name: _____ Relationship: _____ Phone: _____

Insurance Information:

☐ Medicaid (traditional) ☐ Private Health Insurance (Sanford, Blue Cross, United, etc.) ☐ Medicaid (expansion) ☐ *Women's Way*

☐ None/uninsured ☐ Government Insurance (Military, VA)

Name of Primary Insurance	Policy Number	Name of Policy Holder	Policy Holder Date of Birth
Name Secondary Insurance	Policy Number	Name of Policy Holder	Policy Holder Date of Birth

May we submit to insurance? ☐ Yes ☐ No Are you requesting confidential services ☐ Yes ☐ No

I understand: *Medicaid documents containing visit details will NOT be mailed to my home.
*Private insurance companies will send visit details/EOB to your home unless you are Over age 18 and request them to be sent to an alternative location.
(****Explanation of Benefits (EOB) are notifications that insurance companies send that includes payment and visit details****)

Initial Here

Apply for Sliding Fee Scale Discounts (Optional)

Household Size and Income Information:

***__To opt out__ of discount services, skip this section and provide signature in the blue box below.

Household Size: _____

***If under the age of 18 and requesting confidential service, *only report your own income*.

Your Yearly Income before Tax:

$ .00

Job #1_____ hours weekly at $_____ /per hour = $ _____

Job #2 _____hours weekly at $_____ /per hour = $ _____

Partner/Spouse Yealy Income: (include roommates)

$ .00

Job #1_____hours weekly at $_____ /per hour = $ _____

Job #2_____ hours weekly at $_____ /per hour = $ _____

Other Income or Financial Support

Tips or Commission	$_____ per week
Regular Family Support (support by someone not living in the household)	$_____ per month
Grants or Stipends (the amounts used towards living expenses)	$_____ per month
Unemployment	$_____ per month
Alimony	$_____ per month
Income from an owned rental property (NOT amount paid for rent)	$_____ per month

Total Household Income $_____.00

TO OPT-OUT OF DISCOUNTS – REVIEW AND SIGN THE STATEMENT BELOW:

I would not like to disclose my household size and/or income information. I understand that by choosing to opt-out I will not be eligible for discounts on my services today, and I will be charged at the full fee. I understand that after I leave the clinic, I cannot apply for discounts for services that have already been provided.

Signature: _____ **Today's Date** _____

FINANCIAL RESPONSIBILITY CONSENT

I voluntarily request services from Lake Region Family Planning (LRFP) and accept full financial responsibility for any costs after insurance and applicable discounts. I understand that I may set up a payment plan. Amounts with no payments for over 90 days may be released to an outside collection agency, unless services were for a minor requesting confidential status. Essential services will not be denied for inability to pay. If providing insurance, I authorize LRFP to release any information necessary to process my claims to be paid directly to LRFP. I have had the opportunity to review my plan benefits prior to services and choose an in-network provider for optimal coverage.

Signature: _____ **Todays Date** _____

For Staff Use Only:	Household Size	Total Monthly Income	Discount Scale	Staff Initials
			0% 25% 50% 75% 100%	