Jackson County Health Department
FINANCIAL ELIGIBILITY FORM

Patient Name_____
(Last Name) (First Name) (Middle Initial)

Physical Address _____ City _____ State ____ Zip _____

Mailing Address _____ City _____ State ____ Zip _____

DOB_____ **Social Security Number** _____ **Telephone Number**_____

Person responsible for payment _____
(Last Name) (First Name) (Middle Name)

DOB_____ Soc. Sec.#_____ Driver's License #_____ State_____Exp_____

Address if different from patient _____

Do you have insurance that covers your health or dental condition? YES ☐ NO ☐
Name of Insurance Co._____Policy No._____ Group No._____

Name of the card holder (Insured) _____

I understand that I will be assigned to the full fee category and that I am responsible for any charges denied or not paid by my insurance. I also authorize the payment of medical benefits to the Jackson County Health Department. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.

_____ _____ _____
SIGNATURE OF CLIENT/PARENT or GUARDIAN **SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE** **DATE**

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The Jackson County Health Department does not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay and uses recent Federal Poverty Guidelines to establish a sliding fee scale for eligible low-income patients. If you would like to apply for our Sliding Fee Scale please complete the section below.

If you would like to waive the eligibility process please initial here and sign at the bottom. _____ WAIVED

Family Members Name	DOB	Employer / Other	Gross Earned or Unearned Income
SELF			
SPOUSE			
		Child Support Paid Received	
CHILD			
CHILD			
CHILD			
CHILD			
CHILD			

Child care expense per month for each child:	$ and Child's name	$ and Child's name	$ and Child's name	$ and Child's name

I certify that the information on this application is true and accurate. I also understand that falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I understand that by initialing to waive eligibility I am responsible for the **full fee** for services rendered. **I understand that I am financially responsible for payment of fees. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.**

_____ _____ _____
SIGNATURE OF CLIENT/PARENT or GUARDIAN **SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE** **DATE**

(VALID FOR 1 YEAR) Expiration Date:_____
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DECLARATION OF INCOME / CONTRIBUTIONS
FOR CLIENTS DECLARING NO INCOME

1) How many people are in your family unit? _____
(A family is defined as 1 or more persons living in one dwelling place who are related by blood, marriage, law or have a joint child. To be considered a separate family unit, the individual must show he/she can provide for the majority of his/her living expenses.)

2) Do you receive food-stamps? **Y / N**
If yes, you must bring in a letter showing proof of food stamp benefits.

3) How much do you spend on groceries/other necessary items per month? **$**_____
If unknown, estimate a monthly cost of $200 per person in the family unit. $200 X ____ (# of people)

4) How much is your monthly rent or mortgage? **$**_____
If unknown, apply $100 per person in family unit. $ 100 X ____ (# of people)

5) Do you have a vehicle? **Y / N**

6) Do you have a car payment? **Y / N**
If so how much? **$**_____
How much do you pay for auto insurance monthly? **$**_____
How much do you estimate you use in gas monthly? **$**_____

7) Do you have a phone or access to a phone? **Y / N**
If yes to owning a phone, what is your monthly expense? **$**_____
If unknown, apply a minimum of $10.00.

8) How much is your monthly bill for utilities in the household? **$**_____
If living with others, divide the number of adults in household by monthly expense.
If unknown estimate $50.00 per month. $ _____X # of people.

9) How much do you spend monthly on clothing for the family? **$**_____

10) How much are your family medical expenses per month (i.e., medications)? **$**_____

TOTAL $ _____

I affirm that this information is true to the best of my knowledge and I hereby give Jackson County Health Department permission to verify this information.

_____ _____
Client Signature Date Witness Signature Date