Oakland Integrated Healthcare Network

OIHN CARES
DISCOUNT FEE PROGRAM APPLICATION
INCOME AND FAMILY SIZE CERTIFICATION

Head of Household			Home/Cell Phone Number
Street	**City**	**State**	**Zip**
Health Insurance? ☐ YES ☐ NO		**Applicant's Date of Birth**	

For Each Category Below, Enter Number of Family Members In Household	Number
Adults (Do not include your parents, grandparents, aunts, uncles, friends, roommates, children over 18)	
Unmarried Children (full/half/step) under age 19 (Do not include foster children)	
Unborn child of any of above family members	
Total Family Members	
Homeless Individual ☐ YES ☐ NO Adolescent (11-17 years old) ☐ YES ☐ NO	
If homeless individual or adolescent, no proof of evidence required and considered family of one (1) Children and youth in foster care will be seen as a family of one.	

Annual Household Income

Source	Self	Spouse	Other	Monthly Total
Wages, salaries, tips (monthly)				
Social Security				
Pension				
VA Benefits				
Alimony, child support (monthly)				
Self-employment (monthly)				
Other income (monthly)				
Total Monthly Income				**$**

Verification Checklist

Document Type	Yes	No	Unable To Obtain
Prior year tax return			
2 most recent paystubs			
Disability check stub			
SSI check stub			
Current unemployment			
Child Support			
Other written verifiable income statement			

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept in strict confidence. You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Self Declaration of Income

At this time, I can not verify my income due to:_____

_____

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List your spouse and all dependents who are eligible for OIHN Cares-Discount Fee Program			
Name	**Date of Birth**	**Name**	**Date of Birth**
Spouse		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	
Dependent		**Dependent**	

Adolescents will not be denied confidential services because of their inability to pay, including any outstanding balances from co-pays, deductibles and services not covered.

I confirm that the above is truthful and accurate. I agree to inform Oakland Integrated Healthcare Network of any changes in my income in a timely manner. Failure to provide truthful, accurate and/or timely information may result in loss of sliding fee scale privileges.

_____

Patient Signature **Date**

For Internal Use Only

Date: _____Slide: _____

Income: _____ Week / Year / Month

Approved by _____