Shawnee Health Service

SHAWNEE'S FINANCIAL ASSISTANCE PROGRAM INCOME ATTESTATION

Applicant Name: ______________________________ **Date of Birth:** ______________

Complete Any Applicable Section Below

INCOME:

If someone else helps support you, please list the names and their relationship. Have that individual who supports you complete the following information.

Name of Individual: ______________________________

Relationship to you: ______________________________

Type of support provided (housing, food, clothing, transportation, etc.): ______________________________

Telephone: ______________________________

Other Income (Check all that apply)	
I am Unemployed	
I am paid in cash	
I work intermittently	
I am a seasonal farmworker	
I do not file taxes because my only source of income is Social Security benefits	
I do not file taxes because I do not make enough money	
I am living off of my savings account	
I don't have a full 30 consecutive days worth of paycheck stubs	
Other(List reason and submit to Revenue Cycle Director for approval):	
Electronic Verification of Income:	
Means of Verification(Circle One): Website Payroll Bank Statement	
Amount Verified: $	

AGREEMENTS: By signing below, I agree that:

- I certify that the information I provide is true and correct and that if the information proves to be incorrect, the discount will be denied or revoked.
- I understand the information may be reviewed by an auditor of any patient assistance program that I may benefit from.

Applicant Signature: ______________________________ Date: ______________

Signature of Individual that monetarily Supports You (if applicable): ______________________________

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FOR OFFICE USE:

- ☐ Attempted collection of Prior Year's Taxes
  - If unavailable list reason why: ____
  - If they don't file taxes because they don't make enough money, what is their annual income?

    $____________________

- ☐ Attempted collection of last 30 days paycheck stubs (consecutive)
  - If unavailable list reason why: ____
  - Remind the patient to return the remaining 30 days worth of paycheck stubs once received.
- ☐ Attempted collection of social security benefit letter
  - If unavailable you MUST verify the benefit amount by calling Social Security Office

  Date of Call ____________________________________

  Spoke to ____ at Social Security Office

  Amount Verified $________________________________

  Total Annual Benefit $_____________________________

- ☐ If paid in Cash
  - Verify Employer Name____
  - Amount Paid Monthly $____
- ☐ Ran eligibility for Medicaid and offered Case Management assistance to enroll (if applicable)
  - Patient ineligible__________________
  - Patient declined __________________
- ☐ Appointment made with Case Management to provide additional assistance
  - Appointment Date __________________

By signing below, I certify that:

- I exhausted all other means of income verification prior to completing the income attestion form with the patient.

Staff Signature:____ Date:____________________

Supervisor Signature:____ Date:____________________

Interpretation Provided By: ____