Joseph P. Addabbo Family Health Center

Site: []1 []2 []3 [] 5 []6

PATIENT FINANCIAL SCREEN

(Must be completed annually)

Nombre Del Paciente
Patient Name_____

Fecha De Nacimiento
Date of Birth _____ **Chart #** _____

Direccion
Address _____

_____

Tamano De Familia
Family Size _____

Family to be defined as those members residing in a household and dependent upon that household as well as those individuals living outside the household who are dependent upon that household. Non-relatives, such as housemates, do not count as members of the family. **Typically "household" includes the head of household, spouse and dependents**.

Average Gross Monthly or Annual Income: *Include all income for all members living in the household.*

Wages/Salary	**$**	**[] Paycheck Stubs**
Self-Employment	**$**	**[] W-2 or 1099**
Unemployment Benefits	**$**	**[] Tax Return (1040, 1120 etc.)**
Social Security/SSI	**$**	**[] Other**
Child Support / Alimony	**$**	**[] Letter / Screen**
Military Leave	**$**	
Workers Compensation	**$**	
Foster Care	**$**	
Self-Employed	**$**	
Statement from Employer	**$**	
Self-Declaration	**$**	
Total Gross Income	**$**	**[] Per Month [] Per Year**

Clinic	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Ryan White	**A**	**B**	**C**	**D**	**E**	**F**	**G**

□ **Patient refused assessment.**

I understand I am being offered a Sliding Fee discount for services incurred at Joseph P. Addabbo Family Health Center regardless of my insurance status or ability to pay. If I do not choose to accept this discount, I will be responsible for any charges I incur for services I receive at Joseph P. Addabbo Health Center.

Firma Del Paciente
Patient Signature_____ **Date** _____

Completed by _____ **Date** _____
For the Joseph P. Addabbo Family Health Center, Inc.

Courtesy Visit _____ **Date** _____
Supervisor Approval, Site #

Comment:_____