



# INCOME WORKSHEET

NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
FAMILY PLANNING PROGRAM  
SFN 8625 (10-2022)

Patient Number (staff use only)

**There are charges for the services provided for you. These charges may be discounted based on your income and family size. Payment is requested at the time of your visit; however, if payment cannot be made in full, we ask that you make arrangements for payment of any unpaid balance.**

Legal Name (First, Middle, Last)		Former/Maiden Name	
Date of Birth		Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	

<b>If Applicable:</b>	Preferred Name	Gender Identity	Pronoun(s)
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Address	City	State	ZIP Code
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Preferred Telephone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Email Address
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Okay to leave a detailed voice mail message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Okay to send a detailed text message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Okay to email you if we can't reach you by phone? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Okay to send mail to your address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Employer
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Marital Status <input type="checkbox"/> Living Together <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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**Emergency Contact Information:** Please tell us who to contact in case of emergency (trusted adult if under 18); An emergency would be severe bleeding, unconsciousness, accident or a condition requiring emergency intervention. **Family planning services DO NOT require parental permission;** however, in an emergency situation, if you are under 18 years of age, we will notify a trusted adult.

In Case of Emergency, Contact:	Relationship	Telephone Number
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Are you Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language
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Race <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian
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**Check if you have any of the following:**

<input type="checkbox"/> Medicaid (traditional)	<input type="checkbox"/> Government Insurance (Military, VA, IHS)	<input type="checkbox"/> None
<input type="checkbox"/> Medicaid (expansion)	<input type="checkbox"/> Medicare	
<input type="checkbox"/> Private Health Insurance	<input type="checkbox"/> Women's Way	

**If you are 17 years old or younger and covered under your parents' or guardians' insurance plan:**

You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder (your parents or guardians) about the health care services you receive at the clinic.

**If you are 18 years old or older and have private insurance coverage and are not the policy holder:**

You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder about the health care services you receive at the clinic. You may contact your insurance company to request that EOBs be sent to you instead of the policy holder to protect your privacy.

May we submit to insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Primary Insurance	Policy Number
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Name of Policyholder	Relationship to Policy Holder	Policy Holder Date of Birth
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Name of Secondary Insurance (if applicable)	Policy Number
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Name of Policyholder	Relationship to Policy Holder	Policy Holder Date of Birth
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Client Signature	Date
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**SLIDING FEE SCALE DISCOUNTS**

**You may be considered for discounts based on your income, regardless of insurance and citizenship status.**

**Would you like to see if you qualify?**

No, I do not want to be considered for sliding fee discounts. Initial Here: \_\_\_\_\_  Yes - Complete sections below.

How many people live in your household including yourself?

**If you are under the age of 18:**

Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.

Complete Option 1 **OR** 2 below:

**OPTION 1:** If you are an unemancipated minor who wishes to receive services without parental consent, charges are based on only your income. Please fill out your income if applicable.

	Hours Worked Per Week	Hourly Wage		Yearly Wage Before Taxes
<b>Current Job</b>			<b>OR</b>	
<b>Second Job</b>			<b>OR</b>	

**OPTION 2:** If your parents are aware that you are receiving services, charges will be based on your household income, please fill out the information below.

	Hours Worked Per Week	Hourly Wage		Yearly Wage Before Taxes
<b>Parent Job</b>			<b>OR</b>	
<b>Parent Job</b>			<b>OR</b>	
<b>Parent Second Job(s)</b>			<b>OR</b>	

	Hours Worked Per Week	Hourly Wage		Yearly Wage Before Taxes
<b>Current Job</b>			<b>OR</b>	
<b>Second Job</b>			<b>OR</b>	
<b>Partner/Spouse Job</b>			<b>OR</b>	
<b>Partner/Spouse Job</b>			<b>OR</b>	

Tips, Commission, Bonuses	per week	Business Income	per month
Alimony	per month	Rental Income (if you rent property to others)	per month
Farm Income	per month	Taxable Amount of Social Security Benefits	per month
Unemployment or Workers Compensation	per month		

**Other Miscellaneous Income:** taxable interest; dividends; taxable refunds, credits, or offsets of state and local income taxes; capital gains, other gains such as assets used in trade or business that were exchanged or sold; taxable amount of IRA distributions; taxable amount of pension and annuity payments; other income (includes prizes and awards, gambling, lottery or raffle winnings; jury duty fees)

Amount Other Income	Notes

**Income that should not be included above:** child support; money or property that was inherited, willed or given as a gift; life insurance proceeds received as result of someone's death; foster care payments; non-cash payments (such as public housing, Medicaid and nutrition assistance)

The answers to the above questions are true and complete to the best of my knowledge.

Client Signature	Date

**For Staff Use Only:**

Is client requesting confidential services?	Household Size	Total Income	Income Code	Staff Initials
<input type="checkbox"/> Yes <input type="checkbox"/> No			/	