TAMA COUNTY PUBLIC HEALTH & HOME CARE

Financial Data Form

Attachment A

(*Information provided is kept strictly confidential*)

Original Date Sent to Patient:	**Please return to** **Tama County Public Health & Home Care by:**

If this form is not returned to our office by the date indicated above, we shall assume you wish to pay full fee and you will be billed accordingly.

Name:	**Soc. Sec. #**		
Address:	**City:**	**State: IA**	**Zip:** 5

I do not wish to disclose my income and agree to pay full fee for services not covered by third party payor.
Date:_____ Signature:_____

If you have chosen to sign above you do not need to complete the rest of the questionnaire.

To be eligible for the sliding fee scale, you must complete the following:

Are you claimed on anyone elses tax form? ☐Yes ☐No

Do you own property other than where you reside? ☐Yes ☐No

Do you fill out Federal and State tax forms? ☐Yes ☐No
If yes, a copy of your federal and state tax forms, and all attachments, MUST be submitted with this financial data.

In order to determine fee status in a non-discriminatory manner, the following financial information is required. If you are unwilling to provide this information, you will be charged the full fee for service.

INCOME:

	Monthly	**or**	**Yearly**
Salary/Wages - W2 Form	$_____		_____
Social Security	$_____		_____
Farm/Business/Property **(Net Income)**	$_____		_____
Pensions	$_____		_____
Dividends/Interest(1099)*	$_____		_____
S.S.I./F.I.P.	$_____		_____
Other	$_____		_____
TOTAL INCOME	**$_____**		**_____**

**** If you have indicated interest income you must also show the amount of the resource such as a savings account, C.D., etc.***

EXPENSES:

Medical Insurance Premiums, (*Annually*) $_____

Pharmacy Bills, (*Annually*) _____

Medical Bills Above and Beyond Insurance _____

TOTAL EXPENSES..... $_____

RESOURCES:

Savings Accounts $_____

Checking Accounts _____

Stocks/Bonds _____

CDs/Trust Accounts _____

Mutual Funds/Annuities _____

Partnership Resources _____

Buildings/Property _____

Other _____

TOTAL RESOURCES..... $_____

List others living in your household:

NAME	RELATIONSHIP

Please provide the name, address and phone numbers of EACH and EVERY bank or financial institution you utilize or have utilized within the past year:

NAME ADDRESS PHONE NUMBER

_____

_____

_____

_____

I, _____, authorize and give permission to the above
(please print)
named bank, institution, or entity, to provide any financial information to the Tama County Public Health & Home Care, and, in signing this release, I agree to release and hold such bank, financial institution, or entity, harmless from any liability for the release of such information to the Tama County Public Health & Home Care. A photocopy of this release may be given the same full force and effect as the original release.

_____ _____

Signature **Date**

BELOW FOR OFFICE USE ONLY

Total Income $_____ Total Deductible Expenses _____ Total Adjusted Income _____ TOTAL RESOURCES $_____	

_____ _____

CFO/Fiscal Administrator Date

_____ _____

Agency Director Date