FAMILY PLANNING SERVICES SLIDING FEE SCALE

First Name _____ Middle Initial _____ Last Name _____ DOB _____

Social Security # _____ Sex F ○ or M ○ Do you have health insurance? _____

The following information will be used to calculate your income and the level of your discount for ***FAMILY PLANNING SERVICES*** such as annual exam, certain types of birth control, and other family planning services**. NON FAMILY PLANNING SERVICES ARE NOT DISCOUNTED.**

List all who live in your home. (Yourself, Spouse and Children)

NAME: FIRST, LAST	HOW IS THIS PERSON RELATED TO YOU?	AGE
(SELF)		

INCOME: List all income received by yourself, parents, and spouse who live in your home. Include income from wages, unemployment, child support, social security, railroad retirement benefits, worker's compensation, and veteran's benefits.

Person who received money	Employer or income source	Amount before taxes or Deductions	How often paid? Weekly, Monthly, Twice a Month,

If no income, how do you meet your living expenses? _____

Documentation of income for the last 30 days is required for all listed income which includes pay stubs, a letter from your employer, copies of checks, or income tax return. I understand that if I do not return the documentation within 30 days I will be denied from the sliding fee scale and any charges that I have incurred during this time frame will be my responsibility at the full fee price.

Does anyone in your home pay child support for a person who does not live with you? Yes ○ No ○
If yes, who pays? _____ Amount? _____

If you want credit for child support you must bring a copy of a cancelled check.

Does anyone in you home pay for someone to care for a child? Yes ○ No ○
If Yes, how much is paid? _____ How often? _____ To Whom? _____
If you want credit for childcare expenses you must bring a copy of a receipt or statement from you childcare provider.

Authorization for family planning services:
I understand that the Family Planning Council of Iowa may review my record in order to verify that quality services were provided. I understand that this information will remain confidential. As a patient of WHFS and desiring free or reduced price for family planning services I verify that the above gross income is accurate to the best of my knowledge and by signing below I agree to the terms and conditions of this program and to any charges that may not be covered by this program.

Signature (patient or guardian)_____ Date _____

I do not wish to participate with the Family Planning Discount and I understand I will be billed & responsible for all fees not paid by a third party. _____ Date _____

for all fees not paid by a third party. _____Date_____

Office use only

FEE LEVEL_____ Proof of income provided_____

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