

TAMA COUNTY PUBLIC HEALTH & HOME CARE

Financial Data Form

(Information provided is kept strictly confidential)

Date Sent to Client:	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:	Zip:

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. Applicants will be required to apply for all State and Federal programs for assistance in which they are eligible for assistance and support. Tama County Public Health & Home Care and Tama County will be payors of last resort.

<u>INCOME:</u>			
	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	\$ _____	_____	_____
<i>* If you have indicated interest income you must also show the amount of the resource such as a savings account, C.D., etc.</i>			

<u>EXPENSES:</u>	
Medical Insurance Premiums,	(Annually) \$ _____
Pharmacy Bills, (Annually)	_____
Medical Bills Above and Beyond Insurance	_____
TOTAL EXPENSES.....	\$ _____

<u>RESOURCES:</u>	
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 including spouse:

Live Alone

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 \$ _____	Fiscal Summary:
---	---------------------------------

 Fiscal Administrator

 Date

 Agency Director

 Date