



# INCOME WORKSHEET

NORTH DAKOTA DEPARTMENT OF HEALTH  
FAMILY PLANNING PROGRAM  
SFN 8625 (Rev. 11-2016)

**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.**

Name (First, Middle, Last)		Former/Maiden Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Address			City			State	ZIP Code
Cell Phone Number	Home Telephone Number	Work Telephone Number	Student <input type="checkbox"/> Yes <input type="checkbox"/> No		Years of Education Completed		
Email Address			Name of Employer			Primary Language	
Marital Status (check one) <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						Are you Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (check all that apply) <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							
Check all the ways we may contact you (by checking the box, you are giving consent) <input type="checkbox"/> Call Cell <input type="checkbox"/> Text Message (outgoing only) <input type="checkbox"/> Email <input type="checkbox"/> Call Home <input type="checkbox"/> Call Work <input type="checkbox"/> Mail <input type="checkbox"/> Don't Contact						Cell Carrier	
Okay to leave a message or voice mail at above-listed contact numbers? <input type="checkbox"/> Yes <input type="checkbox"/> No							

**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	
Do you use tobacco (to include e-cigarette, vaping, chew, pipe, cigarette)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Do you receive medical assistance/ Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		ID Number		Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we submit to insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insurance Company				Contract Number			
Address			City		State	ZIP Code	
Name of Policyholder			Date of Birth		Relationship to Policy Holder		

**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.

Client Signature					Date		
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**FOR OFFICE USE ONLY**

Is client requesting <b>confidential</b> services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chart Number	Total Gross Income	Income Code / %		Staff Initials	
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Services are based on a sliding scale according to your income, please report below (as applicable):

A. SELF (this is your income BEFORE taxes)

Wage per Hour	x	Hours/Week	=	Weekly Total	x 52 Weeks =	Annual Gross Income
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OR

Weekly Gross	x 52 Weeks =	Annual Gross Income
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OR

Gross Every 2 Weeks	x 26 Weeks =	Annual Gross Income
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OR

Monthly Gross	x 12 Months =	Annual Gross Income
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B. OTHER HOUSEHOLD INCOME (income from those people you live with: spouse, partner, parents)

Monthly Gross	x 12 Months =	Annual Gross
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C. OTHER INCOME (social security, tips, unemployment)

Weekly Gross	x 52 Weeks =	Annual Gross Income
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OR

Monthly Gross	x 12 Months =	Annual Gross Income
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Total of all Annual Gross Incomes (A+B+C)
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Total number of household members (including yourself) that depend on this income
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The answers to the above questions are true and complete to the best of my knowledge.

Client Signature	Date
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