



INCOME WORKSHEET
 NORTH DAKOTA DEPARTMENT OF HEALTH
 FAMILY PLANNING PROGRAM
 SFN 8625 (Rev. 8-2012)

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		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Address			City		State ZIP Code
Marital Status	Years of Education Completed	Email Address			Home or Cell Telephone Number () -
Occupation		Name of Employer			Work Telephone Number () -
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 <input type="checkbox"/> Unknown					
Ethnicity - Check at least one <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not Hispanic Origin <input type="checkbox"/> Unknown/Not Reported					
If we need to contact you, may we call or send mail to the above address? <input type="checkbox"/> Yes <input type="checkbox"/> No			Best Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		If no, how may we contact you?
In Case of Emergency, Contact:			Relationship		Telephone Number

GROSS INCOME (before taxes)

Self

Wages per Hour	X	Hours Per Week	=	Total (Gross)
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Other Household Income (include spouse/partner)

Wages per Hour	X	Hours Per Week	=	Total (Gross)
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Other Household Income (child support, social security, tips, and unemployment)

Monthly Total (Gross)

Total Number of Household Members (including yourself) Depending on This Income	Total Gross Income
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Do you receive medical assistance/Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes	ID Number	Do you have health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes-If you want us to file the claim, complete the following:	
Name of Insurance Company		Contract Number	
Address		City	State ZIP Code
Name of Policy Holder		Date of Birth	Relationship to Policy Holder

____ (Please initial). I authorize the release of any medical information necessary to process an insurance claim and payment of medical insurance benefits.

Tobacco Use (client) <input type="checkbox"/> Yes <input type="checkbox"/> No
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The answers to the above questions are true and complete to the best of my knowledge.

Client Signature			Date
Chart Number	Total Gross Income	Income Code	Staff Initials
		/	%