Campbell County Memorial Hospital
CAMPBELL COUNTY HEALTH
BEHAVIORAL HEALTH

INCOME VERIFICATION FORM

Client must fill out an income verification form and provide proof of income as described below along with meeting with a clinician a minimum of every 3 months. Income will be verified every 90 days and a new income verification form must be completed fully to apply for the sliding fee scale. If a client has a change in their income status, it is their responsibility to notify the Financial Specialist at 307-688-5014 or the Patient Account Counselor (Kid Clinic) at 307-688-8700 of changes in household income.

Clients are required to provide <u>one</u> of the following items as verification of income:

1. *Previous or current year tax return (if unemployed)*
2. *Previous year W-2 (if unemployed)*
3. *Current pay stubs (last 4 weeks)*
4. *Verification letter from unemployment*
5. *Child Support Income (if child is receiving services)*
6. *Current Bank Statement (if self-employed, including tips or other wages, not typically reported)*

Client Name:_____ Date of Birth:_____

Eligibility for the sliding fee scale is based on ***total household gross income***. Please list all sources of household income.

Household member: _____ Gross Amount: $_____
Household member: _____ Gross Amount: $_____
Household member: _____ Gross Amount: $_____

Total Household Gross Amount: $_____ Total Annual Amount: $_____

Payroll Frequency: ___Weekly ___ Bi-Weekly ____Semi-Monthly ____Monthly

I certify that all the above information is accurate to my knowledge and any false statements will terminate the sliding fee scale discount for my services with Behavioral Health Services/Kid Clinic.

Signature of Client/Guardian _____ Date:_____

Social Security Number:_____

<u>OFFICE USE ONLY</u>

Approved By: _____ Date: _____ Client Number: _____

Slide Percentage: _____ % Effective Date: _____ Expiration Date: _____

Clinician appointment last 90 days: _____