Guarantor Information

Today's Date: / /

First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Mobile (Cell) Phone #: ( ) -		
Date of Birth: / /		Do you have insurance? (circle one) Yes No		

Marital Status: Single In a relationship Married Divorced Separated Widowed

Household Size

Name	Date of Birth
	/ /
	/ /
	/ /
	/ /
	/ /

NOTE: To comply with federal regulations, in order to give you a discount on our medical and dental services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income every year.
Your yearly income tax return, a copy of your W-2 form, current s paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	$

Sliding Fee Scale:

A – Minimum ($30.00)

B – 75% Discount

C – 50% Discount

D – 25% Discount

E – 10% Discount

F – 0% Discount

I do hereby swear/affirm that the information provided on this application is true to the best of my belief. I agree that any falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform Near North Health Service Corporation if there is a significant change in my income.

Date:____________ Guarantor Name (Print):______________________________

Guarantor Signature:____

Muestra de escala ajustable de cargos: Formulario

Información del Garantir			Fecha de hoy: / /	
Nombre:	Inicial:	Apellido:	Otros nombres:	
Dirección de casa:		Ciudad:	Estado:	Código postal:
Dirección postal:		Ciudad:	Estado:	Código postal:
Teléfono de casa: ( ) -		Teléfono de casa: ( ) -		
Fecha de nacimiento: / /			¿Tiene seguro? (marque uno) Sí No	
Estado civil:	Soltero En una relación Casado Divorciado Separado Viudo			

Miembros del hogar	
Nombre	Fecha de nacimiento
	/ /
	/ /
	/ /
	/ /
	/ /

NOTA: En cumplimiento de las regulaciones federales, para poder ofrecer un descuento en nuestros servicios médicos es necesario que le hagamos algunas preguntas personales. Sus respuestas se archivarán en estricta confidencia. Usted debe verificarnos sus ingresos al menos cada año.
Su declaración de impuestos, una copia de su formulario W-2, los recibos de cheques de nómina del último mes, copias de sus cheques del Seguro Social, u otros cheques que haya recibido, serán prueba suficiente. Sus ingresos anuales y el tamaño de su familia se usarán para calcular el descuento.

Ingresos del hogar			
Nombre	Cantidad	Frecuencia (marque uno)	Empleador:
Usted	$	Semanal Mensual Anual	
Cónyuge	$	Semanal Mensual Anual	
Hijos	$	Semanal Mensual Anual	
	$	Semanal Mensual Anual	
TOTAL	$	Semanal Mensual Anual	

Otros ingresos	Usted	Cónyuge	Hijos	Otros	Subtotal
Seguro Social					
Ayuda pública					
Pensión de jubilación					
Estampillas para alimentos (Food Stamps)					
Pensión infantil, pensión alimenticia					
Ingresos de intereses					
				TOTAL	$

Escala ajustable de cargos:

A – 30.00 Dolarás

B – 25% de descuento

C – 50% de descuento

D – 75% de descuento

E – 10% de descuento

F – 0 % de descuento

Por el presente documento, yo juro o afirmo que la información que se proporciona en esta solicitud es verdadera y correcta a mi leal saber y entender. Acepto que cualquier información engañosa o falsa, o cualquier omisión, me podrían descalificar de la consideración para el programa de escala ajustable de cargos, y me someterían a las penalizaciones de las leyes federales, que podrían incluir multas y pena de prisión. Además, acepto informar a [nombre del centro médico] si hay algún cambio significativo en mis ingresos. Si consigo ser aceptado para el programa de escala ajustable de pagos a través de esta solicitud, cumpliré con todas las reglas y reglamentos de [nombre del centro médico]. Por este documento, reconozco que he leído y entiendo las declaraciones anteriores.

Fecha:____________________ Nombre (letra de imprenta):______________________________

Firma:____

Near North Health
We'll Find a Way

Zero Income Reporting Form

Applicant Name: ____ ______________________ Date: ______________

Guarantor Name: ______________________________

You have been shown to be at zero income on your submitted verifications since_____. There are normal living expenses that continue even though you are not actively employed.

We are asking you to assist us by answering the following questions.

We are trying to make sure that countable income has not been overlooked.

1. In the past twelve months, have you had any income from any source? ☐ Yes ☐ No
2. Do you have any money in the bank, or put away somewhere? ☐ Yes ☐ No
3. Do you do any odd jobs like field work, babysitting, etc.? ☐ Yes ☐ No
4. Do your parents, children, friends, or any other person outside of your household give you help to meet your needs? ☐ Yes ☐ No If so, what kind of help and how often?

   ____

   ____

   ____

5. In the past months when you say you have had minimal, or no money, how did you, or do you, pay for the following:

   A. Rent? ______________________________

   B. Electricity? ______________________________

   C. Telephone? ______________________________

   D. Other utility bills? ______________________________

   E. How do you buy food? ______________________________

   F. How do you buy cleaning supplies (dish soap, laundry soap, cleaning supplies, etc.)?

   ____

   G. How do you buy paper supplies (toilet paper, paper towels, etc.)?

   ____

   H. How do you buy personal hygiene items (shaving cream, shampoo, deodorant, etc.)?

   ____

   I. Do you smoke? ☐ Yes ☐ No If yes, how do you buy cigarettes?

   ____

J. Do you have cable TV? ☐ Yes ☐ No If yes, how do you pay for this service?

____

K. How do you get around?

____

If you own a car, how are expenses (gas, oil, insurance, etc.) paid?

____

L. Do you have payments on charge cards or charge accounts? ☐ Yes ☐ No

If yes, how are they paid? ______________________________

M. Do you have medical expenses? ☐ Yes ☐ No If yes, how are they paid?

____

Additional comments:

____
____
____
____
____
____

______________________________ ______________________________
Signature of Interviewer Signature of Applicant

______________ ______________
Date Date

This form is used by Near North Health to assist in the verification process of applicants who have claimed zero income.

Near North Health
We'll Find a Way

Zero Income Reporting Form

12 MONTH INCOME REPORT FOR APPLICANTS CLAIMING ZERO INCOME

Begin this report form by filling in the current month in the first column. Then continue down the page with the preceding months.

Month	Source of Income (Employer, ADC, Support)	Amount of Income (Gross Amount) Self employment, Family, Etc.	If Stopped, Why?

I ☐ Did ☐ Did Not **File a Federal Income Tax Report Last Year.**

PLEASE READ:
By my signature I certify that the information I have provided above is true and complete to the best of my knowledge and belief. I understand that this document will be attached to my permanent medical record as verification of my zero income status.

Signed: ______________________________ Printed Name: ____________________

Date: ________________

Zero Income Reporting Form

Guidelines Related to Zero Income Applicant

When an applicant has been determined to be at zero income, the applicant will qualify for payer category A (minimum) for each Medical, Dental and/or Comprehensive Services visit. The applicant will be solicited for updated Income information at each subsequent presentation.

If after one year the applicant continues to seek qualification for minimum pay status based on zero income, the applicant must complete a new zero income questionnaire.

Statement of Financial Status

As of (______________), I (_________________________________) declare that I do not
Date Print Patient / Responsible Party Name

receive any source of monetary wage, financial compensation, financial assistance or financial benefits. I understand that this document serves as my proof of non-income, which qualifies me to participate as payer category A (minimum) for services rendered by Near North Health Service Corporation, and that I must report any change to my financial status immediately.

Signed: ________________________________ Date: ______________________
Patient/Responsible Party

Facility: ______________________________ MRN: ______________________________

Near North Health Service Corporation

Self-Identification: Race, Ethnicity, Sexual Orientation & Gender Identity (SOGI) and Preferred Pronoun Questions

Near North Health Service Corporation (NNHSC) is dedicated to providing access to high quality health care, improving the health and well-being of the diverse populations and communities we serve.

Allowing our patients (adults age 18+) to self-identify and collecting this information in electronic health records (EHRs) can help us to respectfully improve health care for all.

Sexual orientation is defined as to which gender(s) a person is physically attracted: to the opposite gender (heterosexual), to the same gender (homosexual), or to both genders (bisexual).

Gender Identity is defined as to a person's identification as male or female, which may or may not correspond to the person's body or their sex at birth (meaning what sex was originally listed on a person's birth certificate).

SEXUAL ORIENTATION

1. Which of the following do you identify most closely with? Select your best answer.

   - ☐ Lesbian, gay or homosexual
   - ☐ Straight or heterosexual
   - ☐ Bisexual
   - ☐ Something else, Please describe
   - ☐ Don't Know
   - ☐ Choose not to answer

GENDER IDENTIFICATION

2. What gender were you assigned at birth on your original birth certificate?

   - ☐ Male
   - ☐ Female

3. What is your current gender identity?

- ☐ Male
- ☐ Female
- ☐ Female-to-male /Transgender Male/Trans Man
- ☐ Male-to-Female /Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Choose not to answer

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4. What is your race?

- ☐ Black/African American
- ☐ Asian
- ☐ Caucasian/White
- ☐ Multiracial
- ☐ Native American/Alaskan Native/Inuit
- ☐ Pacific Islander
- ☐ Other ____________
- ☐ Choose not to answer

5. What is your ethnicity?

- ☐ Hispanic/Latino/Latina
- ☐ Not Hispanic/Latino/Latina
- ☐ Choose not to answer

6. What is your Pronoun Preference?

- ☐ He
- ☐ She
- ☐ Other ____________

7. Do you have an EMAIL that you'd like to share? Please Print.

____