Planned Parenthood of the North Country New York, Inc.

Income Verification Worksheet

Name_____ Date of Birth _____ Date _____ SS# _____
Address _____Zip Code_____ Phone # _____

We are a government funded agency. Regulations require us to assess income to determine fees. Be aware if total household income is not provided, you will be required to pay full fee for services received. Please give completed form to the receptionist.

You may qualify for FREE services! Ask about Family Planning Benefit Program TODAY! Our staff will assist you with the application and collect all required documentation for this program. If you are eligible, this program will pay for your Family Planning Exams, Pap Smears, Birth Control, Emergency Contraception and more.

Family Planning Extension Program – The Family Planning Extension Program extends coverage for Family Planning Services for Women and Adolescents who lose their Medicaid eligibility after the end of their pregnancy. The Family Planning coverage can extend up to two years after a pregnancy is completed (It doesn't matter how the pregnancy ended; live birth, abortion, miscarriage and still birth).

New York State Cancer Services Program – This program offers breast exams including a screening mammogram, pap tests, pelvic exams, colorectal screening and diagnostic services up to and including biopsy to eligible women aged 40 and older. Colorectal cancer screening is available for men 50 and older. Our office can provide you with the details on how to contact this program within your county.

Have you had a pregnancy in the last 24 months? _____ Did you have Medicaid or PCAP for this pregnancy?_____
If yes, what was your Medicaid number? _____ If yes, what month/Year did this pregnancy end? _____

1. Highest grade of school **completed** _____ Are you a student at this time? _____Yes _____ No
Full time? ____Part time? .

I CHOOSE NOT TO COMPLETE THIS FORM AND AGREE TO PAY FULL FEE FOR ALL SERVICES RECEIVED.
_____(initial here) If you choose not to provide income initial on the line and stop here OR complete the form to enable us to determine your discounted fees.

2. Do you live with (circle one) parent(s) guardian spouse alone other

3. What is **your** income before taxes?
Pay rate per hour $_____ hours worked per week _____ or $ _____/month
If you receive the following, please indicate the amount. Allowance $_____

4. If you circled **spouse**, what is their income before taxes?
Pay rate per hour $_____ hours worked per week _____ or $_____/month

5. Do your **parent(s)** or **guardian** know you come to Planned Parenthood? _____Yes _____No
Do you know your **parent(s)** or **guardian** income? ___Yes ___No
If yes, what is their income $_____? Is this per week, month or year?

6. If you do not live with a parent or guardian: How much do you pay for rent per month? $ _____

7. Do you receive any of the following? If yes, indicate amount received each month.
$_____ Child Support $_____ Alimony $_____Public Assistance$_____
$_____ Pensions or Other Retirement Income $_____Social Security $_____ Food Stamps $_____
$_____ Heating Assistance $_____ Disability Benefits $_____
$_____ Workman's Compensation $_____Unemployment $_____
$_____ Tips (include "under the table" amounts, if any)
$_____ Scholarships, grants, tuition assistance or financial assistance for college
$_____ Other income sources not included above

8. Do you receive WIC for: infant toddler (age 1 - 5) self (circle all that apply)
$_____ WIC Allowance/Infant = $86.50 per month/Todler = $44.50 per month/Mom = $49.50 per month

9. How many people (including you) are supported by this income? _____

Planned Parenthood staff ***must*** complete:
A. Patient weekly income: multiply total of # 5 by 4.3333 = _____ = Monthly Income
B. Spouse or Parental weekly income: multiply total of # 3 or # 4 by 4.3 = _____
If net (after tax) income provided for # 3 or #4: divide by 75% (.75) for gross income
C. Total monthly income: add A+B+line 7+line 8 = _____ Financial Class Assigned _____ (1-5)
Income updated on Practice One and matches CVR _____ (staff initials)
Contact Status _____ Practice One contact status updated _____ Confidential Minor? _____
FPBP discussed with patient and referred? Yes_____ No_____