BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

Statement of Income

As a Federally Qualified Health Center, Boston Mountain is required to collect income information on all patients even if you choose not to participate in the Sliding Fee Scale Program. Please choose your household gross annual income range:

[ ] $0 - $11,880	[ ] $11,881 - $23,881	[ ] $23,882 - $34,882
[ ] $34,883 - $45,883	[ ] $45,884 - $56,884	[ ] $56,885 - $67,885
[ ] $67,886 - $77,886	[ ] $77,887 - $88,887	[ ] $88,888 - $99,888
[ ] $99,889 - $110,889	[ ] $110,890 - Above	[ ] Choose not to disclose

Please ask the receptionist for more information on the Sliding Fee Scale Program

Number of Household Members (Including Self): _____

_____ _____

Patient OR Parent/Guardian Signature **Date**

Internal Notes:

Select Annual Income, Enter Number of Dependents, If patient elects to not bring in income verification, Select Box None Proof of Income (Patient will be set at 100% responsibility level), and then mark Assign. Also, expire