**Family Planning Coverage and Income Assessment Form for Clients 18 Years and Over**

□ I am covered by insurance and have no concerns about confidentiality. It is okay for Hyndman Area Health Center, Inc. to bill my insurance company.

□ I am covered by insurance, but want to keep my visit with Hyndman Area Health Center, Inc. private. I **do not** want Hyndman Area Health Center, Inc. to bill my insurance company.

□ I have no insurance coverage

This facility receives federal monies to provide free and reduced fee services to low-income, uninsured, and underinsured individuals.

1. In the table below, find the NUMBER OF PEOPLE that live in your household in the column labeled “Family size.”
2. Circle the “Annual Income” range in the row that applies to your family’s household. All income received by your household should be included in that number.
3. Household is defined as anyone living in the home that is dependent of the applicant.

|  |
| --- |
| **2020 Annual Poverty Guidelines** |
| Family Size | No Fee0-100%  | 101%-125%  | 126%-150% | 151%-175% | 176%-200%  | 201%-220%  | 221%- 250%  | >250% and Above |
| 1 | 12,760 | 15.950 | 19,140 | 22,330 | 25,520 | 28,072 | 31,900 | 31,901 |
| 2 | 17,240 | 21,550 | 25,860 | 30,170 | 34,480 | 37,928 | 43,100 | 43,101 |
| 3 | 21,720 | 27,150 | 32,580 | 38,010 | 43,440 | 47,784 | 54,300 | 54,301 |
| 4 | 26,200 | 32,750 | 39,300 | 45,850 | 52,400 | 57,640 | 65,500 | 65,501 |
| 5 | 30,680 | 38,350 | 46,020 | 53,690 | 61,360 | 67,496 | 76,700 | 76,701 |
| 6 | 35,160 | 43,950 | 52,740 | 61,530 | 70,320 | 77,352 | 87,900 | 87,901 |
| 7 | 39,640 | 49,550 | 59,460 | 69,370 | 79,280 | 87,208 | 99,100 | 99,101 |
| 8 | 44,120 | 55,150 | 66,180 | 77,210 | 88,240 | 97,064 | 110,300 | 110,301 |

\*\* In reference to the above table the income ceiling for the no fee schedule is equal to the federal poverty level. The 2020 federal poverty level guideline increases by $4,480 for each additional family member above 8.

□ I decline to give this information. I understand that I may pay the full fee for these services and supplies if my insurance cannot be billed.

Please sign and date below.

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Patient Signature Date