COMMUNITY CLINICAL SERVICES INC.
FQHC - Federally Qualified Health Center
Affiliated with St. Mary's Health System

# 2024 ANNUAL FQHC DEMOGRAPHIC & INCOME VERIFICATION FORM

**Why do we ask for this information?** We are a Federally Qualified Health Center (FQHC). This means that we provide health services to all who seek our care regardless of ability to pay, insurance status, or any other factor. All FQHCs are required to collect this information on an annual basis to inform our programming and to ensure that we can best serve our patients. Please complete all sections on the front page of this form. If you have any questions, please ask any of our staff members. Thank you.

**PLEASE COMPLETE THIS INFORMATION FOR THE PATIENT BEING SEEN FOR A VISIT TODAY.**

## DEMOGRAPHIC INFORMATION

**FIRST NAME: _____ M.I ____ LAST NAME: _____**

**DATE OF BIRTH:** _____/_____/_____

*Questions 1 and 2 are optional for patients under the age of 18, but all are welcome to self-report.*

1. **Gender Identity:** _____ Male _____ Female _____Transgender Man/Transgender Male/Transmasculine

   _____ Transgender Woman/Transgender Female/Transfeminine _____Other _____Do not want to disclose

2. **Sexual Orientation:** ____Lesbian or Gay ____Heterosexual/Straight ____ Bisexual ____Other

   ____Unknown ____Do not want to disclose

3. **HOUSING STATUS:** ____Owning ____Renting ____Public Housing ____Homeless

4. **Farm Work Status:** ____Migratory ____ Seasonal ____Neither (Does not apply)

5. **Veteran Status: Are you a Veteran?** ____ Yes ____No

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## INCOME INFORMATION

**Complete below based on your Family Household Size and Household Income** *(Household income includes all income of everyone residing in a household)*

1. **How many people live in your house/apartment?** *(Circle one)* 1 2 3 4 5 6 7 8 Other
   If "other," please write in your household size here: _____

2. **What is the TOTAL ANNUAL INCOME for all members of the household?** *(Please answer to the best of your ability based on the previous tax year)* **_____** **best estimate is okay. Income will be verified if applying for our sliding fee discount.*

3. **Check here if you have no source of income: ____**

**PATIENT/REPRESENTATIVE SIGNATURE**_____ **DATE:**_____

**PLEASE RETURN THIS FORM TO ONE OF OUR FRONT OFFICE STAFF UPON COMPLETION SO THAT WE MAY UPDATE OUR RECORDS**

- **FOR OFFICE USE ONLY -**

STAFF NAME: _____

DATE PROCESSED: ____/_____/____

IS PATIENT ELIGIBLE FOR SLIDING FEE SCALE BASED ON SELF-REPORTED INCOME? _____ YES ____NO

_____ N/A (INCOMPLETE FQHC FORM)

- If yes, did patient complete a Sliding Fee Scale Application? _____ YES _____NO
    - If yes, initial here to indicate application was sent to public benefits_____
    - If no, initial here to indicate an eligibility letter and application were mailed to patient _____

Initial here once patient chart has been updated with demographic and income information: _____

Scan to media manager once complete.