

**Washington County Public Health & Home Care**  
**110 North Iowa Ave., Suite 300**  
**Washington, IA 52353**  
**319-653-7758 1-800-655-7758 FAX 319-653-6870**  
**TTY/TDD: 319-653-2107**

## Financial Data Form

Client Name \_\_\_\_\_

Number in Household \_\_\_\_\_

In order to determine the sliding fee status in a non-discriminatory manner, the following financial information is needed. If you are unwilling to provide this information, you will be charged the full fee for service.

**Household Monthly Income:**

Salary	\$ _____
Interest	\$ _____
Social Security	\$ _____
Farm/Business/Property (Rent or Contract)	\$ _____
Pensions	\$ _____
Dividends	\$ _____
S.S.I/A.D.C.	\$ _____
Other	\$ _____
<b>Total Monthly Income</b>	<b>\$ _____</b>

**Household Monthly Expenses:**

Medical Insurance Premiums	\$ _____
Medications	\$ _____
Special Equipment	\$ _____
Other	\$ _____
<b>Total Medical Expenses</b>	<b>\$ _____</b>
<b>Adjusted Income</b> (Income - Expenses)	<b>\$ _____</b>

Resources: If your resources are below \$10,000 please check here \_\_\_\_\_.  
 If your resources are above \$10,000 please fill in your resources.

**Household Resources:**

Savings Accounts	\$ _____
Checking Accounts	\$ _____
Stocks/Bonds/CDs	\$ _____
Other	\$ _____
<b>Total Resources</b>	<b>\$ _____</b>

<p><b>_____ WILL PAY FULL FEE,          NO FINANCIAL DISCLOSURE          (Number in household not considered)</b></p>
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**I verify that the above information is correct to the best of my knowledge.**

\_\_\_\_\_  
**Client's Signature**

\_\_\_\_\_  
**Date**

Date Mailed: \_\_\_\_\_