MID-COLUMBIA CENTER FOR LIVING
Income and Benefit Statement

NAME: Last/ First :_____ **DATE:** _____

TOTAL GROSS MONTHLY INCOME (If None = 0000)
(IMMEDIATE FAMILY ONLY): $_____ (If Refused = 0001)

Primary Source of Income / Support:
- □ Wages / Salary
- □ Public Assistance / Social Security / Welfare
- □ Retirement / Pension / SSI
- □ Disability / SSDI
- □ Other / Foster Child / Alimony
- □ None
- □ Unknown

Source of Payment: (mark all that apply)
- □ - Self-Pay
- □ - Medicare
- □ - Medicaid / OHP # _____
- □ - Slide / Financial Assistance Agreement
- □ - Other Gov't Payments – Non Medicaid (Intox Driver Fund)
- □ - Worker's Compensation
- □ - Private Health Insurance _____
- □ - No Charge (Free, charity, research or teaching)
- □ - Other
- □ - Unknown

⇨ Are you covered by any insurance other than listed above? □ Yes □ No If yes, please explain : _____
_____

Dependency:
# of people dependent upon client's household income: _____
# of child dependents: _____

Please List All Household Members:

Name	Age	Relationship to Client

AGREEMENT TO PAY FOR SERVICES

I agree to pay for services at the time of my appointment unless other prior arrangements have been made with MCCFL.

Signature:_____ Date :_____
Client / Parent / Guardian or Personal Representative
for Health Care Decisions