Public Health
Prevent. Promote. Protect.

NORTHEAST HEALTH DISTRICT
FINANCIAL DECLARATION

Please provide the following income information to allow the health department to determine your eligibility for reduced fees. (Note: Income should include all sources; such as wages, Social Security, child support, alimony, and other.)

Number of members in the household: _____

Total household income: $_____ per
_____ Week
_____ Month
_____ Year
_____ Twice a month
_____ Every two weeks

Income Source: _____ Annual _____ Current

You may opt out of providing income, however:
_____ I confirm that I do ***not*** want to provide financial information. I understand that because I have not provided financial information, I will not be considered for any reduced fees.

Do you have any of the following types of insurance coverage?

_____ Medicaid (including Amerigroup, CareSource, Peach State or Wellcare)
_____ Medicare or Medicare Advantage
_____ PeachCare
_____ Private insurance
_____ No insurance

Please provide insurance card(s) for any coverage selected above so we can determine if the health department is in-network with your plan(s).

Consent and Statement of Accuracy of Information Provided:
I consent for services to be performed by the Health Department. I understand that full payment in cash or by credit or debit card is required at the time services are rendered and that I am responsible for 100% of all applicable Board of Health scheduled fees unless I qualify for discounts offered by certain programs. I understand that discounted fees are based on my own income, and/or my household income, and my number of dependents, which I have provided truthfully and accurately.

Client Last Name: _____ Client First Name: _____

Client Representative Information *(if signing for Client)*:

Last Name:_____ First Name: _____ Birthdate:_____

Relationship to Client:_____ Race:_____ Sex:_____

Client / Representative Signature:_____ Date:_____