FINANCIAL REDETERMINATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FINANCE
SFN 1226 (2-2025)

Clear Fields

Privacy Statement: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

Client Name	Client ID	Home Telephone Number	Case Manager	
Client Address	City		State	ZIP Code

RESPONSIBLE PARTY INFORMATION

Last Name	First Name		Middle Initial	
Relation to Client	Gender ☐ Male ☐ Female	Social Security Number *	Home Telephone Number	
Employer	Occupation		Work Telephone Number	
Responsible Party Mailing Address	City		State	ZIP Code

The Income and Expense section must be completed to be eligible for sliding fee scale.

Is client a recipient of Medical Assistance (Medicaid)?

☐ Yes - Only verify income if client has "QMB only" coverage. (HSZ/County has verified income for regular MA plan)

☐ No - Attach income verification documents to this form. The primary method of income verification is a copy of your most recent pay stubs. Other acceptable documents include benefit notices and bank statements for SSI, SSDI, Interest Income, VA Benefits, etc. If you are self employed, a seasonal worker, or your income is from a combination of salaries and other income, provide a copy of your most recent income tax form.

HOW TO DEFINE FAMILY MEMBERS:
A family is defined as one or more adults and children, if any, related by blood or law, and residing in the same household. Children who are adults (all persons 18 years of age and older) are not considered the responsibility of their parents, even if living in the same household.

HOW TO FIGURE FAMILY INCOME:
You must report income from head of household and their spouse.

HOW TO FIGURE MEDICAL DEDUCTIONS:
A medical deduction is allowable for any medical insurance paid by the individual and for regular monthly payments on medical bills. The amount deducted must be itemized.

Family Income Information		**Family Expense Information**	
Number in Family		Child Support Payments (for children not claimed as dependents)	$
Temporary Assistance	$	Medical Deductions (Itemize)	$
Gross Wages and Salary	$		$
Alimony or Child Support (When counting children as dependents)	$		$
Veterans Benefits	$		$
SS/SSI/SSDI (Including dependent children)	$		$
Other Income (Describe Type and Amount)	$	Child Care Expenses (incurred because of employment)	$
	$	Alimony Paid	$
	$	Nursing Home Expense	$
TOTAL INCOME	$	TOTAL EXPENSE	$

Insurance Information and/or Medical Assistance (Medicaid) Information

We need a copy of your insurance card, if not previously provided. If you don't have a card, contact your insurance carrier. Failure to provide us with insurance company insurance will result in FULL FEE for services.

Primary Insurance

Name		Effective Date of Policy	Policy Number
Client Relation to Policyholder ☐ Child ☐ Other ☐ Self ☐ Spouse	Policyholder Full Name		
Policyholder Address		City	State / ZIP Code
Policyholder Telephone Number	Policyholder Employer		Work Telephone Number
Policyholder Date of Birth	Gender ☐ Male ☐ Female	Group Number (if applicable)	Plan Number (if applicable)

Secondary Insurance

Name		Effective Date of Policy	Policy Number
Client Relation to Policyholder ☐ Child ☐ Other ☐ Self ☐ Spouse	Policyholder Full Name		
Policyholder Address		City	State / ZIP Code
Policyholder Telephone Number	Policyholder Employer		Work Telephone Number
Policyholder Date of Birth	Gender ☐ Male ☐ Female	Group Number (if applicable)	Plan Number (if applicable)

Tertiary Insurance

Name		Effective Date of Policy	Policy Number
Client Relation to Policyholder ☐ Child ☐ Other ☐ Self ☐ Spouse	Policyholder Full Name		
Policyholder Address		City	State / ZIP Code
Policyholder Telephone Number	Policyholder Employer		Work Telephone Number
Policyholder Date of Birth	Gender ☐ Male ☐ Female	Group Number (if applicable)	Plan Number (if applicable)

Federal Regulations state the following must be billed to you at full fee. We cannot apply the sliding fee scale to: Medicare deductible or copay, Medical Assistance (Medicaid) Recipient Liability. Medicaid Expansion copay amounts are also exempt from the sliding fee scale.

I certify that the information provided is true to the best of my knowledge. I authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Health and Human Services for the purpose of verifying income. **I understand that if any information necessary to verify my income is not provided, the Human Service Center will charge me the FULL FEE for any service provided.** This authorization will remain valid for 1 year or until income changes. A copy of this authorization is as valid as the original.

Signature of Responsible Party or Legal Representative	Date

Office Use:

Income Verified ☐ Yes ☐ No	Sliding Fee Discount	HSC Staff Initials	Date Entered