CLIENT INFORMATION

Name: _____

Birthdate _____/_____/_____ Social Security # _____-_____-_____

Address (including apartment, city and zip code): _____

_____

May we send mail? no____ yes____May we telephone you? no ____yes____ phone# _____
May we leave a text message at this phone number? no____ yes_____ Text #:_____
May we send email messages? No____yes____ email_____

Please Note: Email from Open Door Clinic is not encrypted.

Name(s) of any Physicians you receive care from _____

Pharmacy you use _____ Phone Number _____

Case Manager _____ Behavioral Health Provider _____

For our funding, we must have copies of your I.D., insurance, and income amount. You will be asked to update this information semi-annually.
PLEASE CHECK ALL THAT APPLY:

___ **Medicaid Attach copy, both sides**

___ **Medicare Attach copy**

___ **Private Insurance Attach copy, both sides**

___ **Veteran's Health Benefits Attach copy**

___ **I have no Private Insurance, Medicaid, Medicare Insurance or Veteran's Health Benefits. I am requesting to apply for Open Door Clinic Sliding Fee Discount.**

I receive the following amount of income each month _____ from _____
(Please include all sources of income.) Need verification of income (Check stubs or tax returns)
Please provide a copy of Drivers License.
The number of persons in you household for which you are legally responsible is _____.

I, hereby certify the above information to be correct.

_____ _____
Signature **Date**

1665 Larkin Avenue | Elgin, Illinois 60123 | t • 847.695.1093 | f • 847.695.0501
157 S. Lincoln Avenue, Suite K | Aurora, Illinois 60505 | t • 630.264.1819 | f • 630.229.0182

Revised 01/01/2015

Client Member Consent to Service Agreement

I, _____ agree to actively participate in Open Door's services outlined in the Service Plan that the staff and I have developed. This Service Plan will help to access needed resources and support.

I understand that Open Door exists for the purpose of assisting people impacted by HIV in receiving the level of advocacy, support and assistance necessary to manage HIV.

I understand that program services include, but are not limited to primary care; case management; assessments, advocacy, information and referrals; linkages to external agencies; individual, couple and family counseling; support groups; dental; and educational services.

I understand that information regarding my request for services, the service I receive, or the extent of my discussions with Open Door's staff will not be disclosed without my informed consent.

I agree to respect the confidentiality of other client members in the agency and will not disclose personal information discussed in-group sessions outside the agency.

I understand that Open Door staff need to periodically contact client members by phone or conduct home visits, but in these instances will not disclose the nature of their contact to unauthorized persons.

I have received a copy of "Your Rights and Responsibilities" form and the agency "Grievance Procedure."

Confidentiality of client information is of the utmost importance in the provision of services, and Open Door strives to protect the privacy and confidentiality of our clients. This policy is intended to ensure confidentiality of all clients' information and to define the parameters of appropriate disclosure.

Client Information is any information that can be used to identify a client with reasonable accuracy, either directly or by other publicly available information. Client identifying information includes the following: their name (first or last); social security number; address; date of birth; physical description; or photograph.

Disclosure is revealing information the identity, HIV status, or medical condition of any client receiving services. Any release of information, formally or informally, which would identify an individual as a client, either directly or by reference to other publicly available information, is disclosure. As a publicly identified service provider for persons with HIV/AIDS, indicating to a third party that someone is a client of the agency without the client's consent is disclosure and a breach of his/her confidentiality.

Consent for release of information is client authorization for disclosure of specific information to a

particular recipient for an explicit purpose. Before information about a client can be released or obtained by Open Door the client must first be informed of the reason. Next, the client must sign a release of information to authorize staff to either release or obtain information pertaining to the client. A client may refuse to sign a release of information at any time for any reason.

Under the following circumstances, Open Door staff may release information about a client without the client's prior consent and approval:

- when releasing information to a judge or court of law, when the client's records are subpoenaed by the court;
- when releasing medical information pertinent to a medical emergency (where blood is present) when the client or client's guardian or caretaker is unable to provide consent;
- when any other laws or regulations require disclosure, such as state reporting of HIV surveillance, without a client's consent.

Psychotherapeutic, psychiatric and other mental health services are confidential. We will not reveal any information you disclose in treatment to persons or agencies outside the Open Door without your written consent, except when required by law.

The law requires that we inform others outside the clinic when one of the following conditions exists:

- When there is reason to suspect that child or elder abuse has occurred, regardless of when the abuse may have occurred.
- When there is reason to believe that a patient is likely to harm him or herself, unless the service provider has taken protective measures.
- When there is reason to believe that a patient is likely to harm someone else.

Senior-level practitioners may supervise others in training at the Open Door. All supervisors adhere to the same professional guidelines as stated above. However, Open Door cannot release any information regarding a client's HIV status under any circumstances without a signed release of information.

I have read and understand the information outlined, and I consent to treatment under these conditions.

Give permission for Open Door staff to contact me via:

- ☐ US Postal Service: (Address) _____
- ☐ Telephone Number: _____
- ☐ E-mail: _____
- ☐ Text: _____

Any special provisions for ongoing contact with Open Door staff include the following:
_____.

_____ _____
Client Member Signature Date

_____ _____
Staff Member Signature Date

Statement of Client Rights and Responsibilities

I. Description of Services

A. Primary Care: Early intervention medical care consisting of physician services, nutritional screening, nursing, laboratory testing (limited), Psychosocial, Mental Health, Psychosocial & Substance Abuse (assessment, treatment plan, and recommendations), Dental Services (Preventative, Diagnostic, and Therapeutic) and referrals for other specialty care services.

B. Case Management: Provide needs assessment, develop individualized service plans, and support and entitlement programs, resource referrals and other services which become part of the Case Management program.

II. Eligibility

A. Case Management/Mental Health-Substance Abuse Treatment/ Psychosocial Services/Dental Care: Persons living with HIV disease in Kane, Kendall, Suburban Cook, Lake, McHenry, and surrounding counties.

B. Primary Care: Persons diagnosed with HIV disease unable to secure medical care from private physicians. Person must be over sixteen years old.

C. Open Door reserves the right to limit or withhold any services based upon need and the compliance of each client.

III. Non-Discrimination Statement

Persons will not be denied service based on race, religion, sex, sexual orientation, handicap condition, nationality legality, veteran status, social and/or economic status/group membership, literacy, homelessness and substance abuse, developmental disability, or mental health issue.

IV. Confidentiality

Open Door respects your rights as an individual and considers the protection of these rights as important to the agency. These rights include:

A. The right to seek help through our services without danger of disclosure. We will not give out any information about you or release any information from your file without your permission.

B. The right to have a private space for conversation, intakes, conferences, etc.

C. Clients are responsible for respecting the privacy and confidentiality of other clients receiving services at Open Door including not discussing client members with people outside the clinics.

D. Open Door does have the responsibility to transmit electronically either by email or fax confidential information for continuity of care, treatment, healthcare operations and billing purposes. It is understood that all caution possible will be made to avoid email or fax information from being received in error by a third party. The use of email and fax will be limited to:

1. Communication with Open Door physicians for continued medical care between medical clinics;

2. Billing purposes to 3rd party insurances including Private Insurance, Medicare, Medicaid and Ryan White funding sources;

3. Communication with other medical resources for continuity of care where releases of information have been signed.

V. Client Rights are:

A. To have information kept in the strictest confidence in compliance with the laws of the State of Illinois.

B. To decline services at any time and sever relationship between Open Door and yourself.

C. To know where to register complaints and concerns.
D. To know what information about you is being released, to whom and for what purpose.
E. To receive alternative services from other organizations with or without the assistance of staff.
F. To participate with Medical, Behavioral Health, and Case Manager in formulating and executing a service plan.
G. To be treated with respect, civility and courtesy by the staff of the Open Door.
H. Services will be provided in a safe and secure location.

VI. Client Responsibilities are:

A. To interact with the staff of the Open Door in a civil manner, openly and honestly.
B. To limit expectations of the programs to deliverable services as originally outlined.
C. To comply with the service plan created and agreed upon.
D. To participate fully and accept responsibility for tasks and actions.
E. To assume financial responsibility for services outside those of Open Door when those services are requested or suggested.
F. To inform Open Door staff of any changes that might affect services.
G. Illicit drugs, alcohol, implicit or explicit weapons are prohibited on agency's premises.
H. To not verbally or physically threaten staff.

VII. Grievance Procedure

Persons receiving services from Open Door through Primary Care, Behavioral Health, or Support Services (DRS or Part A Case Management) have the right to file grievances with the agency pertaining to those services. The following procedure will be followed in order to address such grievances.

A. Discuss issue with person providing the particular service. An attempt of resolution might be obtained through discussion and mutual agreement between staff and Client.
B. If necessary, the Client will submit their grievance in writing to the Executive Director of the Open Door with specific details. The Executive Director will investigate and respond in writing within fifteen days of the receipt of the grievance.
Letters will be addressed to:

Executive Director
Open Door
1665 Larkin Ave.
Elgin, IL 60123

C. If necessary, a meeting will be arranged between the Executive Director, the pertinent staff member, the Client and, if desired, their representative. If resolution is not possible, efforts will be made by the staff of the Open Door Clinic to secure services for the Client through another provider.
D. At any point in the grievance process you may contact the Center for Conflict Resolution (CCR) to provide to you a confidential process to discuss your concern(s) with the agency in the presence of a neutral mediator to create options and find a mutually agreeable solution. You may contact CCR through the following toll free number 1-866-CARE-212. For Part A Case Management or Part B services grievance please contact, Mike Grego at 1-312-784-9089.

I have read my rights, responsibilities and service descriptions as listed above. They have been explained to me and I fully understand them. I certify I have received a copy of these rights and responsibilities for future reference. I give my consent for emails and faxes to be sent as outlined in section IV on Confidentiality. I absolve Open Door of all liability in the event an email or fax is received in error by a third party.

Please initial the correct response:

I do want a copy of the Rights and Responsibilities for my records. _____

I do not want a copy of the Rights and Responsibilities for my records. _____

Client Signature _____ **Date**_____

Staff Signature _____ **Date** _____

Provider Notice of Information

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $.15 (15 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose you information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:

David M. Roesler / Executive Director
1665 Larkin Avenue
Elgin, IL 60123
PH: (847) 695-1093 **E-Mail:** Droesler@opendoorclinic.org

I have received a copy of this document.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

www.opendoorclinic.org

OUT OF POCKET MECIAL EXPENSE TRACKING FORM

Please put all receipts from medical expenses, including over-the-counter medications, into this envelope and bring to Open Door with your appointments. Give to receptionist to review and return to you. Please provide a receipt to receptionist.

Name: _____

2015 Spending Cap: _____

Examples: Medical Expenses	**Date**	**Amount**	**Running Total**
Vitamins	1/15/09	$9.99	$9.99
Mammogram	2/1/09	$40.00	$49.99
ODC Office Visit	2/15/09	$10.00	$59

Medical Expense	Date	Amount	Running Total

I acknowledge that the Caps Program was explained to me and I was given the medical expense tracking form.

_____ _____

Client Signature **Date**

_____ _____

Staff Signature **Date**

1665 Larkin Avenue | Elgin, Illinois 60123 | t • 847.695.1093 | f • 847.695.0501
157 S. Lincoln Avenue, Suite K | Aurora, Illinois 60505 | t • 630.264.1819 | f • 630.229.0182

Revised 01/01/2015

CONSENT TO RELEASE INFORMATION

Subject to the limitations and conditions set forth below, I, _____hereby consent to _____ ("Provider/Case Manager"), acting through its employees or agents, to use and/or disclose my health information and medical records to the AIDS Foundation of Chicago, the Northeastern Illinois HIV/AIDS Case Management Cooperative (the "Cooperative") and/or any agencies that provide services through the Cooperative (collectively the "Recipients"), as follows: (i) in connection with my participation in the centralized client database established by the AIDS Foundation of Chicago (the "Database") and the operation of the client database; (ii) to enable the AIDS Foundation of Chicago and the Cooperative to conduct quality assurance programs for individuals receiving case management services through the Cooperative; (iii) to avoid duplication of services by case management agencies; and (iv) in connection with the submission of reports and other data to funding sources.

In connection with my enrollment in the Database, I hereby give my consent for the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (when applicable), date of birth, mother's maiden name, and other demographic data. In addition, verification of HIV-positive status (if applicable) and dates of medical and case management service will be released to the AIDS Foundation. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

I further allow the program staff of the AIDS Foundation of Chicago and its designated Oversight Committees of the Cooperative to review my individual service records as part of the Cooperative's quality assurance program. For the purposes of this consent, I acknowledge and agree that my service records include any and all records generated by any of the Provider agencies that participate in the Cooperative.

Any information I provide for the purposes of receiving services will not be disclosed to any government agency or health department for purposes of surveillance, contact tracing, or any other purpose other than obtaining health care or social services, except (1) with my consent, (2) as required by law, or (3) if necessary, to prevent a serious attempt to inflict harm on myself or others. Security precautions will be maintained to prevent unauthorized access to the Database by anyone other than the program staff of the AIDS Foundation of Chicago.

I give further consent to allow the AIDS Foundation of Chicago to report information that I provide in connection with my enrollment in the Database and in connection with my receipt of services to the federal grant programs that support the AIDS Foundation of Chicago. I understand that such information may be provided either in the aggregate or on an individualized basis. I understand that, in order to protect my privacy, any information that is provided on an individualized basis, with the exception of Part B funded service utilization, will be furnished using unique client codes, without names or other information that identifies me.

I further understand that should I receive service funded under Part B of the Ryan White

CARE Act, certain information will be reported to the Direct Services Unit of the Illinois Department of Public Health, including:
- demographic information, including but not limited to name, gender, race, ethnicity, and birth date; service utilization information; HIV/AIDS diagnosis and treatment information, if any; and mental health and/or substance use diagnosis, treatment, and service information, if any.

I understand that this information will be shared for the purposes of evaluating Part B service utilization patterns, on-site service reviews, and when necessary to coordinate services.

I further agree that the Direct Services Unit of the Illinois Department of Public Health may disclose this same type of information to my provider/case manager, and/or the Cooperative.

I can terminate this consent by submitting a written request to any of the Recipients (agencies in the Cooperative) indicating that I no longer desire to receive services through the Cooperative, or my written revocation of this authorization, whichever occurs first.

I understand that I may refuse to sign this consent and that may result in being denied services, if eligibility for services is based on the verification of my diagnosis and the release of that information. I understand that I have the right to receive a copy of this consent. I further understand that I may revoke this consent at any time by providing written notice of my intent to revoke this consent to Provider. This consent cannot be revoked to the extent that action has already been taken based on this consent.

This consent is valid for a period of one year from the date of the actual client signature below.

Provider will not use or disclose personal health information beyond the scope of this authorization without your written consent or authorization. Please note that, subject to applicable law, disclosed information may be subject to redisclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____
Signature of Client or Client's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than client)

ILLINOIS Department of Public Health
Ryan White Part B Program

Authorization for Release of Health Information

First Name	Middle Initial	Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)
	/ /

Please read all statements and sign in the space provided to certify that you have read and understand this authorization. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information in this application is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.

2. I understand that the information requested on this application is for the purpose of determining my eligibility for a state and federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available.

3. If I am considered eligible for services, my information will be utilized with our contractual partners for the reasons explained in this document. Eligibility approval does not mean I will receive or be enrolled in all services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.

4. Upon approval, my eligibility will expire after six months. Prior to the conclusion of my six months, I will be required to reapply and provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification of Eligibility every 6-months as per Federal Guidelines.

5. I agree to notify, or to have my Medical Case Manager notify, the program(s) of any circumstances affecting my participation in, or eligibility for, the program(s). I agree to notify the program(s) within thirty (30) days of a change in address and understand that all program correspondence will be sent to the address I have on file with the program(s). I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program(s).

6. I authorize the program to release my enrollment, eligibility and service utilization records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, or entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program as outlined in the bullet point list below.

7. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.

8. If I request enrollment into Medical Case Management or request any service that requires coordination with a Medical Case Manager, my information will be shared with the Medical Case Management provider that the Care Connect Regional Lead Agent who is administering this program in my area assigns to me.

9. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the IDPH for any unused premium payments should my insurance policy terminate or be cancelled for any reason; including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.

10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH), or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).

11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.

12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L 104-491, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this program.

13. I understand that I may revoke this authorization at any time in writing. Unless revoked, the release shall remain valid for a period of **24 months** from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also understand that each time I sign a new authorization form on a 6 month basis for renewal purposes that any and all previous authorization(s) become null and void.

    a. This authorization refers to authorizing the release of information for a validity period spanning 24 months from the date this form is signed. This authorization will provide permission for reengagement activities to take place by designee(s) of the Department not to exceed 24 months from the date of signature, for those instances when I may step away from care after a 6 month certification.

The agencies listed below are utilized to coordinate and verify eligibility for all services, and for treatment and care coordination with other program(s) within IDPH, following the same confidentiality requirements identified above in statements 1-13:

- System Software Vendor *
- Premium Assistance Payment Vendor*
- Pharmacy Benefits Manager Vendor*
- Quality Assurance & Compliance Vendor*
- Centers for Medicare & Medicaid Services
- IL Department of Insurance
- DIS Outreach Specialists employed by IDPH and/or local Health Departments
- Chicago Department of Public Health
- IL Department of Employment Security (Income Verification Services)
- IL Department of Health and Family Services (Medicaid Verification Services)
- IL Department of Public Health programs per Illinois Statute 410 ILCS 305
- IL Department of Public Health's Office of Health Protection Sections/Programs
- All Ryan White funded Providers

* Specific vendor information can be requested at: **https://www.wh1.ioc.state.il.us**

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact Person listed below, and understand that I will be required to list this contact on each submission of this form. IF YOU WILL NOT BE PROVIDING A CONTACT, PLEASE "X" OUT THIS BOX.

_____
Alternate Contact Person Name

_____
Street Address

_____
City State Zip Code

(_____) _____ - _____ Is this person aware of your + status? ☐ Yes ☐ No
Telephone

_____ / /
Client Signature (age 12 and older) **Date**

_____ / /
Parent/Guardian (if under 12) or Legal Representative **Date**

Addendum for Additional Contacts

(This page required ONLY if additional contacts are listed)

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact Person listed below, and understand that I will be required to list this contact on each submission of this form. IF YOU WILL NOT BE PROVIDING A CONTACT, PLEASE "X" OUT THIS BOX.

Alternate Contact Person Name

Street Address

City State Zip Code

(________) __________ - ______________ Is this person aware of your + status? ☐ Yes ☐ No
Telephone

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact Person listed below, and understand that I will be required to list this contact on each submission of this form. IF YOU WILL NOT BE PROVIDING A CONTACT, PLEASE "X" OUT THIS BOX.

Alternate Contact Person Name

Street Address

City State Zip Code

(________) __________ - ______________ Is this person aware of your + status? ☐ Yes ☐ No
Telephone

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact Person listed below, and understand that I will be required to list this contact on each submission of this form. IF YOU WILL NOT BE PROVIDING A CONTACT, PLEASE "X" OUT THIS BOX.

Alternate Contact Person Name

Street Address

City State Zip Code

(________) __________ - ______________ Is this person aware of your + status? ☐ Yes ☐ No
Telephone

/ /

Client Signature (age 12 and older) **Date**

/ /

Parent/Guardian (if under 12) or Legal Representative

ILLINOIS RYAN WHITE MONTHLY HOUSEHOLD INCOME STATEMENT

Separate section must be filled out for each legal householdmember age 18 and over - even if they do not earn income

****All fields shaded or with *asterisks* with an amount or a "Y" require ADDITIONAL supporting documentation****

Client Name: _____

Date of Birth: _____/_____/_____ **Social Security Number:** _____

Client		Additional Legal Household Member over age 18 Name: _____	
CURRENT MONTHLY Income (cannot leave blank)		CURRENT MONTHLY Income (cannot leave blank)	
Wages, Salaries, Cash, tips, etc.	*	**Wages, Salaries, Cash, tips, etc.**	*
Do you receive pay stubs?	* Y / N	**Do they receive pay stubs?**	* Y / N
Alimony/Spouse Support Received	*	**Alimony/Spouse Support Received**	*
Self Employed/ Business Income/Loss		Self Employed/ Business Income/Loss	
IRA Distributions		IRA Distributionst	
Pensions & Annuities (Veteran or Employer Based Pensions, Retirements,or Disability)	*	**Pensions & Annuities (Veteran or Employer Based Pensions, Retirements,or Disability)**	*
Rental real estate,partnerships, S Corporations, Trusts, ect.		Rental real estate,partnerships, S Corporations, Trusts, ect.	
Farm income or loss		Farm income or loss	
Unemployment Income	*	**Unemployment Income**	*
Retirement from Social Security (SSA)	*	**Retirement from Social Security (SSA)**	*
Disability from Social Security (SSDI)	*	**Disability from Social Security (SSDI)**	*
SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)		SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)	
Other income (Jury Duty,Gambling Winnings)	*	**Other income (Jury Duty,Gambling Winnings)**	*
CHILD SUPPORT RECEIVED, WORKERS COMPENSATION		CHILD SUPPORT RECEIVED, WORKERS COMPENSATION	
DID YOU FILE TAX RETURNS?	* Y / N	**DID THIS PERSON FILE TAX RETURNS SEPARATELY FROM CLIENT?**	* Y / N

Comments:

Additional room for comments on back

Client Signature (REQUIRED) **Date (REQUIRED)**