**Attachment A**
***Revised and Board Approval Date: 12/08/2014***

# COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.
## Income Information/Self Declaration Form

| CCHC – E.R. | CCHC – H.P. | CCHC – N.H. | CCHC-G.L. |
|---|---|---|---|
| 1704 Colorado Blvd. | 5059 York Blvd. | 12157 Victory Blvd. | 801 S. Chevy Chase Dr.#250 |
| Los Angeles, CA 90041 | Los Angeles, CA 90041 | N. Hollywood, CA 91606 | Glendale, CA 91205 |
| 323-256-4116 | 323-344-4144 | 818-755-8000 | 818-265-2264 |

**SECTION A. PATIENT INFORMATION**

**Patient_____ DOB_____ DATE_____**

***To be considered for any cash discount this form must be filled out completely by all patients.**

**SECTION B. HOUSEHOLD/INCOME INFORMATION**

**Family Size _____** **Net Monthly Income $_____**

☐ **Verified**

☐ **Self-Declaration**

**Nominal Fee of $40.00**

* Net family monthly income means the income received by the patient and the patient's responsible relatives less taxes.

I FURTHER CERTIFY AND DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I UNDERSTAND THIS FORM AND THAT THE INFORMATION PROVIDED ABOVE IS TRUE, CORRECT, AND COMPLETE.

Patient/Guarantor's Signature_____ Date_____

PCC Signature_____ Date_____