

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

CCHC – E.R.
1704 Colorado Blvd.
Los Angeles, CA 90041
323-256-4116

CCHC – H.P.
5059 York Blvd.
Los Angeles, CA 90041
323-344-4144

CCHC – N.H.
12157 Victory Blvd.
N. Hollywood, CA 91606
818-755-8000

CCHC-G.L.
801 S. Chevy Chase Dr.#250
Glendale, CA 91205
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 _____ Monthly Income \$ _____

Verified

Self-Declaration

Nominal Fee of \$40.00

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 _____