Income / Self Declaration Form

SECTION A – Patient Information (APPLICABLE TO ALL PATIENTS)

Patient's Name _____ Date of Birth _____

SECTION B – Household/Income Information (APPLICABLE TO ALL PATIENTS)

Household Size (Including Self) _____ Monthly/Annual Income $ _____

SECTION C – Income Evidence (To Be Considered for Sliding Fee Scale We Require Evidence/Proof of Income)

Please list spouse and dependents

Name	*DOB*	*Name*	*DOB*
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Household Income

Source	*Self*	*Spouse*	*Other*	*Total*
Gross wages, salaries ,tips, etc.				
Income from business, self-employment (tax return 1040 line 22, and dependents)				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, other government programs, public assistance veterans' benefits,				
Income earned on investments, alimony ,child support				
Total Income				

NOTE: Copies of tax returns, pay stubs or W2, Self-Declaration, Letter from employer, Public assistance verification letter, signed document by a person providing financial support for the patient, letter from homeless shelter having previously verified income may be required before a discount is approved.

Verification Checklist	Yes	No
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards (For Patient's responsibility)		

SECTION D – Refusal/Declination

☐ Patient Refusal (If a patient refuse to be assessed, the patient will automatically be charge a full charge)

SIGNATURE

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform CCHC if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of CCHC. I hereby acknowledge that I read the foregoing disclosure and understand it.

Patient, Parent, or Guarantor's Signature _____ Date _____

PCC Signature_____ Date _____

Print PCC Name_____