SELF-ATTESTATION OF INCOME FORM

Please complete the information below if you cannot document your income.

Patient Name: ______________________ Guardian Name: ______________________

SSN (Optional): ______________________ Date Of Birth: ______________________

All items below must be answered in order to complete your financial assistance application.

1. Number of people in your household: ________________
2. How do you receive payment for the work you do? ☐CASH ☐CHECK
3. How much do you get paid? $_________________________
4. How often do you get paid?
   ☐ BI-WEEKLY
   ☐ WEEKLY
   ☐ OTHER (*explain*): ___________________________
5. Type of work: ____

APPLICANTS/RECIPIENTS MUST READ THE FOLLOWING AND SIGN BELOW: *I certify that all of the above information is true and accurate. I understand that this information is to be used to determine eligibility for Financial Assistance.*

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Patient Name (Printed)

____ ____________________

Patient/Guardian Signature **Date**