Health Partnership CLINIC

SELF-ATTESTATION OF INCOME FORM

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

Patient Name: _____ Guardian Name: _____

SSN (Optional): _____ Date Of Birth: _____

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

1. Do you have a paycard? ☐ YES ☐ NO
2. Do you or your spouse/partner have a checking account? ☐ YES ☐ NO
3. Do you or your spouse/partner have a savings account? ☐ YES ☐ NO
4. Do you file taxes or does anyone claim you on their taxes? ☐ YES ☐ NO
5. How do you receive payment for the work you do? ☐ PAYCARD ☐ CHECK ☐ CASH
6. How much do you get paid total each month? $_____
7. How often do you get paid?
   ☐ BI-WEEKLY
   ☐ WEEKLY
   ☐ OTHER (*explain*): _____
8. 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.*

*I understand that **falsified** documentation is subject to **penalty** and can disqualify me or family members from financial assistance.*

_____
Patient Name (Printed)

_____ _____
Patient/Guardian Signature **Date**