GOOD SAMARITAN

RURAL HEALTH CENTERS/CLINICS

PATIENT SELF-DECLARATION OF INCOME FORM

Complete the information below only if you have no other way to document your income. Failure to complete this form may result in denial of your application from the Sliding Fee Discount Schedule Program.

Check all that applies:

☐ I am currently unemployed.

☐ I get paid in cash/non-payroll checks

☐ I do not get payroll checks.

☐ I do not get pay stubs.

☐ I cannot get a letter from my employer establishing my income. **Explain why:**

_____

_____

My gross household income is $_____ (circle one: per week / month / year) and there are _____ family members living in my household.

Current Employer _____

Employer Address _____

Employer Phone _____

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for the Sliding Fee Discount Schedule ("SFDS") Program. I understand that the RHC may verify information on this form. I also understand that if I intentionally misrepresent my income, I may be denied from the SFDS Program, may have to repay benefits received, and may be prosecuted under the law.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature (Patient/Parent/Guardian) Date