Self-Declaration of Income

Sliding Fee Applicant Name: _____ **Date of Birth:** _____

Family Member Name: _____ **Date of Birth:** _____

1. **Please indicate the reason why you are unable to provide proof of income:**

   - ☐ I have no income.
     - If you have no income, skip to question 5.
   - ☐ My employer pays me in cash.
   - ☐ I do not receive pay checks.
   - ☐ I do not receive pay stubs.
   - ☐ My employer will not provide a letter

2. **Where do you work or what type of work do you do?** _____

3. **How often are you paid?**

   - ☐ Weekly
   - ☐ Every Other Week
   - ☐ Monthly
   - ☐ Twice a Month
   - ☐ Other (please explain) _____

4. **How much money do you receive each time you are paid?** _____

5. **Please read the following statement and sign below.**
   I certify that I have no other way to document my income and that all the above information is true and correct. I understand that this information is to be used to determine eligibility for the patient assistance programs at White House Clinics. This documentation will become part of the medical record for all patients identified as family members in the household on the sliding fee application.

_____

Patient Signature

Internal Use Only (should be completed by WHC employee who completes financial statement with patient)

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation.

_____	_____	_____
Employee Signature	**Printed Name of WHC Employee**	**Date**