COMMUNITY HEALTH AND DENTAL CARE

Self-Declaration of Income and Housing Form

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Please complete the information below:

_____ I get paid in cash

_____ I do not get pay checks

_____ I do not get pay stubs

_____ Estimate, No Documentation Provided

_____ I cannot get a letter from my employer. Explain why:
_____

My Income is $ _____ How Often (Weekly, Monthly) _____

Current Employer or the Type of Work that I do is _____

Complete the information below only if you have no other way to document your housing.

I, _____ certify that I am currently residing at the following address:
_____

My average monthly housing cost is $ _____. If needed, you may contact the following person to verify this information.
Name: _____ Telephone: _____
Address: _____

I certify that I have no other way to document my income and/or housing and that all of the above information is true and correct. I understand that this information is used to determine eligibility for the Healthcare Sliding Fee Discount Program. I understand that the program officials may verify information provided on this form. I also understand that if I intentionally misrepresent my income, I may have to repay the benefits received. I understand that this application may be subject to change after final administrative approval.

Signature: _____ Date: _____ Slide Amount Approved _____
(Patient)
Signature: _____ Date: _____
(CHDC Staff Person)
Signature: _____ Date: _____
(CEO)