



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: _____

(Patient)

Date: _____ Slide Amount Approved _____

Signature: _____

(CHDC Staff Person)

Date: _____

Signature: _____

(CEO)

Date: _____