CHDC Your Health. Our Community.

ch-dc.org
610-326-9460

Self-Declaration of Income

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Are you currently insured? (check only one) ☐ Yes ☐ No

Do you need assistance verifying eligibility for insurance? (check only one) ☐ Yes ☐ No

Please complete the information below:

☐ I get paid in cash

☐ I do not get pay checks/ pay stubs

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

_____

My gross income is: $ _____ How often: (weekly, monthly) _____

Please give a brief explanation of your income stated above: _____

_____

_____

_____

_____

_____

If your income is $0.00, are you listed on any recent Federal 1040 Tax Return: ☐ Yes ☐ No

If yes, please include a copy of the Federal 1040 Tax Return you are listed on.

If your income is $0.00, who is currently supporting you? _____

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 used to determine eligibility for the Healthcare Discount Program. I understand that the program administrators may verify information provided on this form. I also understand that if I intentionally misrepresent my income, I may have any applied discount(s) revoked and will be responsible for repaying any discount(s) already received. I understand I must submit a new application every calendar year and that this application may be subject to change after final administrative approval.

Signature: _____ Date: _____ Slide Amount Approved: _____
(Patient)

Signature: _____ Date: _____
(HCDP Coordinator or CHDC Representative)

Signature: _____ Date: _____
(CEO)