**Self-Declaration of Income Statement**

**Name: _______________________________________________ DOB: __________________________**

I am unable to provide proof of income and must self-declare my income by completing this form. I understand that I must report any income I received during the twelve months prior to the date of this declaration.

**Sources and amounts of income listed in the application for which I have no proof:**

**Source: _______________________________________ Amount for the last 12 months: ____________**

**Reason I cannot provide proof:**

_______________________________________________________________________________________

_______________________________________________________________________________________

**Source: _______________________________________ Amount for the last 12 months: ____________**

**Reason I cannot provide proof:**

_______________________________________________________________________________________

_______________________________________________________________________________________

**Source: _______________________________________ Amount for the last 12 months: ____________**

**Reason I cannot provide proof:**

_______________________________________________________________________________________

_______________________________________________________________________________________

**Source: _______________________________________ Amount for the last 12 months: ____________**

**Reason I cannot provide proof:**

_______________________________________________________________________________________

_______________________________________________________________________________________

**If you declared zero income please explain your current living situation and how your monthly expenses are met.**

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

I declare the above information is true and correct. I understand that this information will be kept in strict confidence. I also understand that if my income or "family size" should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

**Patient Signature _______________________________________________________ Date ___________**

**Self-Declared income must be approved by the Team Lead or COO (signature acknowledging approval is required on the Sliding Fee Application).**

Revised 5/4/2021