Sample Self-Declaration Form

Patient Information	
Patient's Name:	Patient D.O.B:
Address:	Phone Number:

Declaration of Employment:

I ____ declare that my principal

employment is in agriculture and that presently: [ ] I am working [ ] I am not working

Employer Name:____

Employer Address:____

Declaration of Income and Family size:

I declare that my household income last (select one) ____month **or** ___ year

was $__________________. I also certify that a total of ___________ people (including spouse,

children, parents, grandparents, etc.) are living in my household.

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for ____days.

I have been informed that I must provide the required documentation within ___ days in order to continue to receive the Sliding Fee Discount.

I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center but I will not have access to a discount.

Applicant Signature:__________________________________ **Date:**_________________