CHCB 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 _____ 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 for last year was $_____ and that my

monthly family income is $_____. 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 90 days.

I have been informed that I must provide the required documentation within 90 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 have to pay 100% of my medical bill.

Applicant Signature:_____ **Date:**_____