Elica Health Centers

SLIDING FEE PROGRAM SELF-DECLARATION FORM

Patient Name	**MRN:**	**Today's Date** (month/day/year)

If you do not have financial support or documentation of your income, you can let us know by filling out this form.

To self-attest, please select 1 of the following options and sign at the bottom.

I certify that I have no other way to document my income. This is because:

- ☐ I am paid in cash. I do not get paychecks/pay stubs.
- ☐ I am unable to provide any proof of income because neither I nor any other member of my household has any source of income.

I certify that I have no other way to document my income. I affirm that the above information is true and correct to the best of my knowledge. I understand that if the information I give is determined to be false, I will be denied financial assistance, and I will be responsible for and expected to pay for the services provided.

_____ _____

Patient/Legal Guardian Name (Print)

Relationship to patient of Individual Signing Form
(For example, patient, parent, guardian)

_____ _____

Patient/Legal Guardian Signature

Date

VERIFICATION AND DETERMINATION (Office Use Only)

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used my best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature: _____ Date: _____