# UNICARE COMMUNITY HEALTH CENTER, INC.

## SELF-ATTESTATION INCOME APPLICATION

*This form should be used by patients who have no other type of documentation to verify their income.*

| **PATIENT INFORMATION** | | Today's Date: / / | |
|---|---|---|---|
| First Name: | Middle: | Last: | Date of Birth: |

*Unicare Community Health Center is required to verify the household income of patients accessing services.*

☐ I get paid in cash, do not receive my pay stub and my employer will not provide me a letter confirming my payment.

☐ I am self-employed and do not file taxes. Please indicate your gross monthly income: $_____

☐ I do not receive any income (Complete the below.)

I, _____ (Print Full Name), do hereby certify that I (and my family) do NOT receive the following income from ANY source. I understand sources of income include, but are not limited to, the following:

- Wages, salaries, and tips
- Social Security benefits
- Unemployment compensation
- Self-employment or business income
- Alimony
- Retirement and pension income
- Investment and rental income
- Other Taxable Income

*Please explain below how you (or your family) have paid for these two living expenses when your household has had no income.*

Utilities: _____

Housing: _____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me and my family from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Unicare Community Health Center if there is a significant change in my income. If acceptance to the sliding fee discount program is obtained under this application, I will comply with all rules and regulations of the Unicare Community Health Center. I hereby acknowledge that I read and understand the foregoing disclosure.

SIGNATURE DATE

PRINT NAME

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**INTERNAL USE ONLY**

Eligible Family Size: _____ Total Gross Household Income: $ _____ Scale: _____

*This Self-Attestation Income Application is effective from* _____ *to* _____.

REVIEWED BY: UCHC STAFF (SIGNATURE) DATE

APPROVAL BY: OFFICE MANAGER (PRINT NAME) SIGNATURE