CLINCH RIVER HEALTH SERVICES

SLIDING FEE PROGRAM
17285 Veterans Memorial Hwy
Dungannon, VA 24245
276/467-2201
276/467-2673

Self Declaration of Income

(Not Currently Employed)

I,_____, certify my total income is $_____ per week/month/year (please circle).

Household/Family Size: _____ **HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents**

I am currently:
- ❑ Unemployed – looking for employment
- ❑ Unemployed – seeking disability
- ❑ Disabled – receiving disability benefits
- ❑ Retired
- ❑ Other_____

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Clinch River Health Services for sliding fee determination purposes.

Signed:_____ Date:_____

Instructions: If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors.

Statement of Personal Assistance

I, _____, assist _____ (patient) by providing basic living needs listed below:

Shelter: ❑Yes ❑No Relationship to Applicant:_____
Food: ❑Yes ❑No
Money: ❑Yes ❑No Amount $_____

I can be reached to verify this information at:

My Name (Please print):_____

Address: _____

Phone: _____

Signed:_____ Date:_____

Please list any special circumstances on the back of this form