17285 Veterans Memorial Hwy
Dungannon, VA 24245

CLINCH RIVER HEALTH SERVICES, INC.

Phone: 276-467-2201
Fax: 276-467-2673

SLIDING FEE PROGRAM

Self-Declaration of Income
(Not Currently Employed)

I, _____, certify that my total income is $_____ per month/week/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:

Name (Please Print): _____

Address: _____

Phone: _____

Signed: _____ Date: _____

Please list any special circumstances on the back of this form.