PROJECT HOME
HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION
STEPHEN KLEIN WELLNESS CENTER

PATIENT INCOME SELF-DECLARATION FORM

NAME: _____
Last name First name Middle Initial

DOB: _____ PATIENT MEDICAL RECORD NUMBER: _____

HEAD OF HOUSEHOLD / RESPONSIBLE INFORMATION (if different from above):

NAME: _____ DOB: _____
Last name First name Middle Initial

INCOME AND DEPENDENTS INFORMATION
Please answer the following:

1. Total Number of Dependents: _____ (count yourself, your children under 18, and your spouse or significant other if they live with you)

2. *Please check all that apply:*

☐ I work and make $_____ per hour / per week / per month / per year. Hours per week: ____.

Name of Employer_____

☐ I am not employed.
☐ I am not employed and have no income.
☐ I receive unemployment compensation, TANF, social security or other government assistance and the amount is $_____ per month.
☐ I receive child support of $_____ per month

Spouse/Significant Other's information (if they live with you):

☐ My spouse/significant other's income is: $ _____ per hour / per week / per month / per year. Hours Per Week: ____.
☐ My spouse/significant other has no income.

I, the undersigned patient or the parent, spouse, or legal guardian of the patient, certify under penalty of perjury that the information above is correct. I understand that refusal to disclose adequate financial information for the Sliding Fee Pay discount application will result in being assessed the entire cost of my medical visit.

_____
Signature Date

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the reasons why the acknowledgement was not obtained.

☐ Individual refused to sign.

_____ _____
Signature of Project HOME representative Date

Funded by HRSA

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