Attachment G

**NEIGHBORHOOD HEALTH CENTER SLIDING FEE  
SELF-DECLARATION FORM**to be filled out by patient

**Date: \_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

To whom it may concern:

I declare that my **\*\*gross monthly income is** \_\_\_\_\_\_\_\_\_\_\_\_and my **\*\*\*family size is** \_\_\_\_\_\_\_\_\_\_\_\_\_.

\*\*Gross Income includes:

* Employment \_\_\_\_\_\_\_\_
* Pension \_\_\_\_\_\_\_\_
* Social Security \_\_\_\_\_\_\_\_
* Disability \_\_\_\_\_\_\_\_
* Child Support \_\_\_\_\_\_\_\_
* Alimony \_\_\_\_\_\_\_\_
* Work Comp \_\_\_\_\_\_\_\_
* Unemployment \_\_\_\_\_\_\_\_
* Additional income \_\_\_\_\_\_\_\_

\*\*\*Family Size includes

* All people living in same household

*I hereby request Neighborhood Health Center to make a determination of my eligibility for the sliding fee program. I understand that the information, which I submit concerning my family income and size, is subject to verification. I also understand if the information, which I submit, is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Neighborhood Health Center of all changes to my insurance information and, should I fail to do so, Payment in full will be my responsibility.*

*\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_*

***Patient Initials Representative Initials***

Please use this in determining my Sliding Fee Eligibility.

Yours Truly,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**