summit community
CARE CLINIC

Self-Declaration of Income

Patient Full Name: _____

Date of Birth: Month: ___ Day: ___ Year: _____ Phone Number: _____

Mailing address: _____

Email address: _____

Please read carefully and complete the following information:

- Complete this form ONLY if you have no other way to verify your income.
- All boxes must be filled out. Failure to complete this form in its entirety, or leaving blank spaces will result in your application being determined incomplete, and your application will be rejected.

I declare that my total gross income (for my entire household for earned, unearned, donations, etc.) is the amount of $ _____ per:

(circle one) day week every 2 weeks month year

*I certify that I have no pay stubs or other documentation to prove my household earnings for the following reason (please mark with an "X" ALL that apply):

- ☐ I receive cash payments.
- ☐ I receive cash donations.
- ☐ I do not receive checks or paystubs.
- ☐ I cannot get an employer letter.
- ☐ Other (explain) _____

_____

_____

I also state that there are _____ total household members including myself, my spouse/partner, and minors (if applicable) under the age of 18 living in my household.

Patient signature _____
Date of completion: Month: ___ Day: ___ Year: _____

If applicable patient verbal signature received by (SCCC employee Name): _____

STAFF USE ONLY:

Employee name _____

SFC#_____ Patient ID _____ Received _____

Revised 03/01/24.