North Mississippi Primary Health Care

Self-Attestation of Income – Sliding Fee Discount Program

Fill out the following information if you are ***unable*** to provide documentation of your household income

Patient Name: _____ Date of birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Family Size*:*

Family size is defined as a group of two (2) or more persons (one of whom is head of household) Relationship by birth, marriage, adoption, and cohabitation. Household size will be limited to immediate family; spouse, children, and dependents.

Circle One: 1 2 3 4 5 6 7 8 Other: _____

Family member's name	Relation	Date of birth

I currently **don't have any documentation** to verify my income. The reason(s) are:

Check all that apply	
☐	I get paid in cash
☐	I didn't file a tax return last year
☐	I cannot get a letter from my employer
☐	Other (Please explain)

Please include below the amount of support you receive each month and the source of the support

Monthly Income (Check all that apply)		Amount:	Source:
☐	Cash	$	
☐	Rent	$	
☐	Food	$	
☐	Cell phone	$	
☐	Gas	$	
☐	Other:	$	

Reported Monthly Income: $_____ (Sum of all amounts listed above)

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Reported Annual Income: $ _____ (Reported monthly income x 12)

Family Size: _____

Slide Class: A B C D E

Page 2 must be signed for the form to be completed

Under penalty of perjury, I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information will be used to determine eligibility for the **North Mississippi Primary Health Care Sliding Fee Discount Program.** I agree that any misleading or false information or omission will subject me to penalties under federal law, which may include fines and imprisonment.

Patient's Signature: _____ Date: _____

STATE OF MISSISSIPPI

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for said county and state, on this _____ day of _____, _____, within my jurisdiction, the within named _____, who acknowledged that (he/she/they) executed the above and foregoing instrument.

Notary Public

Printed Name: _____

My Commission Expires: _____

Notary Stamp Here