PRIORITY HEALTH CARE©
A UNIVERSAL APPROACH TO CARE

SELF-DECLARATION OF INCOME FORM

Patient Name

Mailing Address | **City** | **State** | **Zip Code**

Phone | **Email**

This is to certify the income status for the above named individual. Income includes but is not limited to:

- The full amount of gross income earned before taxes and deductions.
- The net income earned from the operation of a business, i.e., total revenue minus business operating expenses.
- This also includes any withdrawals of cash from the business or profession for your personal use.
- Monthly interest and dividend income credited to an applicant's bank account and available for use.
- The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
- Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker's compensation.
- Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
- Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
- All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

Check only one box and complete only that section.

☐ I certify, under penalty of perjury, that I currently receive the following:

I declare that my household income is $ _____ per ☐ week ☐ every other week ☐ month ☐ year.

☐ I certify, under penalty of perjury, that I do not have any income from any source at this time.

Patient Acknowledgements

I declare, under penalty of perjury, that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

I hereby acknowledge that I am applying for assistance under a U.S. HRSA funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

Patient, Parent or Guardian Signature _____ **Date** _____

FOR OFFICE USE ONLY

Patient Name _____

Staff Verification

I understand that third-party verification is the preferred method of certifying income for discounts under Priority Health Care's Sliding Fee Scale Program.

Further, I understand:

- the Self-Declaration of Income Form is only permitted when I have attempted to but cannot obtain third-party verification of income; and
- it is my responsibility to ensure **three (3) documented verification attempts** are completed **after** the initial visit, but **before** expiration of the approved Sliding Fee Scale application.

	Verification Attempt 1	Verification Attempt 2	Verification Attempt 3
Date			
Communication Method	☐No Contact ☐Phone/Fax ☐In-Person ☐Patient Portal	☐No Contact ☐Phone/Fax ☐In-Person ☐Patient Portal	☐No Contact ☐Phone/Fax ☐In-Person ☐Patient Portal
Income Verified?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Income Updated in Nextgen?	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Documentation	☐Wages And Salary ☐Self Employed ☐Unemployment Benefits ☐Social Security ☐Child Support / Alimony ☐Worker's Comp ☐Veteran's Benefits ☐Military Pay ☐Income From Rent ☐Interest/Dividends/ Royalties ☐Private Pensions and Annuities ☐N/A	☐Wages And Salary ☐Self Employed ☐Unemployment Benefits ☐Social Security ☐Child Support / Alimony ☐Worker's Comp ☐Veteran's Benefits ☐Military Pay ☐Income From Rent ☐Interest/Dividends/ Royalties ☐ Private Pensions and Annuities ☐N/A	☐Wages And Salary ☐Self Employed ☐Unemployment Benefits ☐Social Security ☐Child Support / Alimony ☐Worker's Comp ☐Veteran's Benefits ☐Military Pay ☐Income From Rent ☐Interest/Dividends/ Royalties ☐Private Pensions and Annuities ☐N/A

Staff Signature _____ **Date** _____

Revenue Cycle Notification

Method	Date	Staff Name
☐Email		