No Proof of Income Worksheet

Patient Information

☐ New Patient ☐ Established Patient

First name: ______________________ Last name: ________________________ Date: ______________

Social Security #: ______________________________________ Birthdate: ________________________

Phone number: ______________________ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please answer the following questions and provide additional information when required:

Have you applied for Medicare, Medicaid, Marketplace (ACA), or Children's Health Insurance Program (CHIP)?	☐ No	☐ Yes
Does someone provide financial support for you?	☐ No You are self-attesting to $0 income, signature required.	☐ Yes Please answer the questions below.

Who provides financial support for you?

First name: ______________________ Last name: ________________________ Date: ______________

Relationship to patient: ____

Address: ______________________________________ Phone number: ________________________

Questions below need to be answered by the person who provides financial support

Patient fees are based on the type of service provided and the patient's income and family size. Our patient has listed you as the person who is financially supporting them. Please answer the following questions.

How long has the patient been living with you: ____________________ year(s) ________________ month(s)

How much financial support did you provide last month? i.e. rent, utilities, or food: $__________________________

Please provide a brief description of the situation: ____

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Identified patient supporter signature: ____________________________________ Date: ______________

I certify that the information given on this form is complete, true, and correct. If found to be untruthful, I understand that access to CDHC services may be terminated. I understand that financial assistance will expire on the date listed on the *Financial Assistance Application* and I will be required to reapply. If there is a change in income, I will submit a new *Financial Assistance Application*.

Patient signature: ____ Date: ________________

Office Use Only: Patient MR #: ____