Charles Drew
HEALTH CENTER, INC.
"Growing a Healthy Community"

SELF-ATTESTATION WORKSHEET

Patient Information

☐ New Patient ☐ Established Patient

First name: _____ Last name: _____ Date: _____

Birthdate: _____ Phone number: _____

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

Do you receive income that you are **able** to provide documentation for (i.e. paystubs, tax returns, self-employment ledger, etc.) but do not have it with you today?	☐ No	☐ Yes, I self-attest to: $ _____ Please provide documentation within 30 days.
Do you receive income that you are **unable** to provide documentation for (i.e. paystubs, tax returns, self-employment ledger, etc.) and would like to self-attest your household income?	☐ No	☐ Yes I self-attest to: $_____ How often (weekly, monthly, etc.) _____
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: _____

_____

Identified patient supporter signature: _____ Date: _____

I certify the information given on this form is complete, true, and correct to the best of my knowledge. If found to be untruthful, I understand access to CDHC services may be terminated. I understand 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/Guarantor signature: _____ Date: _____

Office Use Only: **Patient MR #:** _____

March 27, 2018 HCM