Foothills Health & Wellness Center

A program of Kentucky River Foothills Development Council, Inc.

SELF-ATTESTATION OF INCOME

Please complete the following information below if you cannot provide documentation of your household income.

Patient Name: _____ Birthdate:_____

Address: _____

City: _____ State: _____ Zip Code: _____

All items below must be answered in order to complete your Sliding Fee Scale Application at **Foothills Health and Wellness Center**.

How is your payment received? Cash ☐ Check ☐

How often do you get paid? Bi-Weekly ☐ Weekly ☐ Other ☐

What is the gross amount? $_____

Where do you receive your income from?

Wages from Employment	_____	Retirement	_____
Self-Employment Wages	_____	Black Lung	_____
Social Security Checks	_____	Alimony	_____
Disability Checks	_____	Child Support	_____
Farming Income	_____	Military Wages	_____
SSI	_____	Unemployment	_____
VA Pension	_____	Rental Property	_____

Other (Please explain) _____

Applicants (Recipients must read the following and sign below):

I certify that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for **Foothills Health and Wellness Center Sliding Fee Discount Program.**

Signature of Applicant: _____ Date: _____