AMOSKEAG HEALTH

**SELF-DECLARATION OF CASH INCOME EARNED** (Separate form must be completed for each applicant in the household that receives cash income)

FIRST NAME LAST NAME DATE OF BIRTH

STREET ADDRESS CITY/STATE/ZIP CODE PHONE NUMBER

PLEASE INCLUDE THE MOST RECENT CONSECUTIVE 4 WEEKS OF CASH INCOME EARNED:

| DATE | SOURCE OF INCOME (Describe) | $ AMOUNT RECEIVED |
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"I, (print patient/applicant name)_____, hereby declare under the penalty of perjury and the laws of the United States of America that the information provided above is true and correct and this is an accurate statement of my cash earnings during the time period indicated above. Furthermore, I understand that failure to provide accurate information regarding my financial status may result in the termination of my sliding fee discount services at Amoskeag Health. I also understand that I may be prosecuted for fraud."

_____ _____

Patient/Applicant Signature Date

_____ _____

Staff/Witness Signature Date