Affidavit of Income

Patient Full Name (print): _____ DOB: _____

By filling out the form below, I agree the information I provide may qualify (but does not guarantee) me for a reduced cost for the services I receive at OLE HEALTH. If I do qualify, I agree to pay the reduced charge (sliding fee) in full.

_____ (← initial) I agree I may be asked to pay for the full cost of the services I receive if I have not told the entire truth and/or have falsified information on this from.

_____ (← initial) I have been provided a copy of OLE HEALTH's "Proof of Income Verification Types" form.

I. Please fill out this section if you <u>will</u> be able to provide proof of income or insurance eligibility:

By signing this section, I understand I have 30 days from today's date to submit proof of income or proof of insurance to avoid paying the full cost for the services I received at OLE HEALTH. I understand that bringing proof of income or insurance only qualifies me to be eligible to receive services at a reduced cost.

Patient Signature: _____ Date: _____

II. Please fill out this section if you <u>will not</u> be able to provide proof of income or insurance eligibility: *

Did you have any family members in your household who contributed income to your household in the past year? Please list the **<u>number</u>** of persons in your household and the total **<u>monthly</u>** income amount combined:

Number of persons: _____ Monthly Income Amount: $_____

I, _____ hereby verify that I do not receive any income
(Print your First and Last Name)

from any of the following sources:

- Wages from employment (including commissions, fees, tips, bonuses etc.)
- Income from operation of business, self-employed or other employed status
- Rental income from real or personal property
- Interest or dividends from assets
- Social Security payments, annuities, insurance policies, retirement funds, pensions, SSI (Supplemental Security Income), or death benefits
- Unemployment or Disability payments
- Public Assistance payments
- Regular monthly payments received from family or friends
- **Any other sources not mentioned above**

I understand I must report any changes to my income or assets to OLE Health during my next visit. I understand I forfeit my right to be eligible to receive services at a discounted rate if I provide any false statements or information.

Signed: _____ Date: _____

If signing on behalf of patient, (minor, etc.) please print your relationship: _____

**Section II expires 1 year after signature date*

Affidavit of Income

OLE HEALTH
Live Life Well

PROOF OF INCOME VERIFICATION TYPE
(New proof of income must be presented every 12 months)

EARNED INCOME FROM EMPLOYER (PERMANENT OR TEMPORARY)):

- **One Pay Stub:**
  - Must show **gross** earnings and number of hours worked
    (Copy of the actual check is not acceptable because it doesn't show gross income).
  - Must be dated for current or prior month.

OR:

- **Letter from Employer:**
  - Must show gross earnings, number of hours and dated from current or prior month.
  - Must be signed by employer with contact information.

OR:

- Most recent **W2 or Income Tax return** (pay stubs preferred, may be more current).

SELF-EMPLOYED:

- Most recent **Income Tax return.**

OR:

- If no tax return has been filed, **Extension Form.**

UNEMPLOYMENT OR DISABILITY:

- **One Check Stub** must be dated from current or prior month.

OR:

- **Award letter** must be dated from current calendar year.

PUBLIC ASSISTANCE:

- **Napa County Health & Human Services Agency "Passport to Services"** with most current data.

OR:

- Recent **Public Assistance application** including financial information.

MEDI-CAL (applied but not yet approved):

- **Recent application** including **financial information.**