HOPE CLINIC
delivering hope & health

Patient ID: _____

**Self Declaration**

***Please complete the written attestation below as verification of how you meet your expenses.***

*Please Print:*

Patient Name: _____

Patient DOB: _____/_____/_____

I, _____ attest that my current
(First Name) (Last Name)

income is $ _____ on a monthly basis. I affirm this to be true and further

state that I have no supporting documentation regarding this income for the following reason(s):

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Enroller: _____ Date: _____