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: ______________