

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 form.

_____ (← 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 will 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: _____

Did you have any family members in your household who contributed income to your household in the past year? Please list the **number** of persons in your household and the total **monthly** 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: Per Covid-19, Information and consent verbally captured by _____ Date: _____

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

**Section II expires 1 year after signature date*