



# Tri-Area Community Health

**SLIDING FEE PROGRAM**  
Corporate Office, PO Box 9  
Laurel Fork VA 24352  
276/398-1215  
276/398-1273 FAX

[www.triareahealth.com](http://www.triareahealth.com)

## Self Declaration of Income (Not Currently Employed)

I, \_\_\_\_\_, certify my total income is \$\_\_\_\_\_ per week/month/year (please circle).

Household/Family Size: \_\_\_\_\_ **HOUSEHOLD = Applicant + Spouse/Significant Other + Legal Tax Dependents**

- I am currently:
- Unemployed – looking for employment
  - Unemployed – seeking disability
  - Disabled – receiving disability benefits
  - Retired
  - Other \_\_\_\_\_

I certify that all statements contained herein are true/correct, and subject to investigation. I also authorize the release of employment records and other financial information to an agent of Tri-Area Community Health for sliding fee determination purposes.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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**Instructions:** If you have NO (or limited) income and are receiving help from friends/family, the following must be completed, signed and dated by your benefactors.

## Statement of Personal Assistance

I, \_\_\_\_\_, assist \_\_\_\_\_ (patient) by providing basic living needs listed below:

- Shelter:**  Yes  No                      Relationship to Applicant: \_\_\_\_\_  
**Food:**  Yes  No  
**Money:**  Yes  No    Amount \$ \_\_\_\_\_

I can be reached to verify this information at:

My Name (Please print): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

***Please list any special circumstances on the back of this form***