DECLARATION OF INCOME / FAMILY SIZE

I, _____, declare that the INCOME and NUMBER IN FAMILY information listed below is complete and true. I understand that I am being charged for today's visit based on the information provided. I have been informed about the NYS Family Planning Benefit Program and of the required documentation needed for eligibility consideration.

Income: _____(weekly / bi-weekly / monthly)
Number in family dependent on this income: _____

I understand that this form must be completed at each visit unless I provide verifiable proof of income, such as, most recent pay stub, unemployment letter, etc).

☐ I have received information on the Family Planning Benefit Program.

_____

Patient Signature & Date

_____

(Office use only)

Patient Coded: _____ Effective for visit date: _____/_____/_____

Clinic Staff Initials: _____

Reviewed 10/29/08 DOIFS