KIAMICHI
FAMILY MEDICAL CENTER

SLIDING FEE PROGRAM
PO Box 180
Battiest, OK 74722
(580)241-5294
(580)241-5739 FAX
www.kiamichimed.org

Self Declaration of Income

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:
- ☐ Employed at _____
- ☐ 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 KFMC for sliding fee determination purposes.

Signed: _____ Date: _____

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
Food: ☐Yes ☐No Relationship to Applicant: _____
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