FAITH FAMILY
MEDICAL CENTER

PATIENT INFORMATION

- **Patient Name:** _____
- **Date of Birth (MM/DD/YYYY):** ____ / ____ / _____
- **Phone Number:** _____
- **Address:**

DECLARATION OF NO INCOME

I, _____ (print full name), hereby declare that:

1. I currently have **no income from any source**.
2. I am **not employed** in any capacity (full-time, part-time, temporary, or self-employment).
3. I am **not receiving** any of the following:
    - Wages or salary
    - Self-employment earnings
    - Unemployment benefits
    - Disability (SSI/SSDI)
    - Social Security retirement
    - Pension or retirement income
    - Alimony or child support
    - Rental income
    - Cash assistance or financial benefits

- Any other regular or irregular income

4. I understand this information is used solely to determine my eligibility for programs or financial assistance.
5. I certify that all information provided in this declaration is **true, complete, and accurate** to the best of my knowledge.
6. I understand that **providing false or misleading information may result in denial of services** and may carry legal consequences.

PATIENT CERTIFICATION

Patient Signature: _____
Printed Name: _____
Date: ____ / ____ / _____

STAFF / WITNESS VERIFICATION (if required)

Staff/Witness Name: _____
Signature: _____
Date: ____ / ____ / _____