Teche Action Board, Inc.

LACK OF INCOME DECLARATION FORM

Patient Name: _____ Date of Birth: _____

The letter is providing a list of resources that is used as evidence of income to Teche Action Clinic. Please check the boxes that affect your financial situation.

_____I do not receive any income from employment

_____I do not receive any unemployment compensation

_____I do not receive food stamps

_____I do not receive workman's compensation benefits

_____I do not receive any disability income

_____I do not receive any supplemental security income

_____A family member **DOES** support me financially.

How is this individual related to you?_____

What is the amount this individual(s) contributes to you financially?

Amount _____

How often? _____

I certify that the information given on this form is correct to the best of my knowledge. If the information given is proven false, I understand that Teche Action Board, Inc. can disqualify me for any discounts and bill me for all services received and all services paid by Teche Action Board, Inc.

_____ _____

Signature of Patient Date

_____ _____

Signature of Teche Employee Date

Your Primary Care Medical Home

Revised 10-06-2020;12/14/2023
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