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 Health. 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 I received, and all services paid by Teche Action Board, Inc.

_____ _____
Signature of Patient Date

_____ _____
Signature of Teche Employee Date

Revised 10-06-2020;12/14/2023; 01/3/2025
Reviewed 10-01-2022; 12/14/2023