SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Patient Name _____
(Last, First, Middle Initial)

MRN _____
(Medical Record Number)

Patient Statements

☐ **STATEMENT OF INCOME**

I, _____ (First Name, Last Name), am providing this statement to verify my income, as I have no other income documentation available to me. I receive $_____ (Gross Amount) per month, and the frequency of pay is:

☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Twice-a-Month ☐ Monthly ☐ Other _____

I last received this amount on _____ (Date). My employer's name is _____

My employer's phone number is _____.

☐ **STATEMENT OF NO INCOME**

I, _____ (First Name, Last Name), declare under penalty of perjury that I have no income and do not receive any means of financial support, including, but not limited to: Paid Employment; Rental Income; Inheritance; Spousal Support; Interest Payments from Bank Accounts; or any other method.

☐ **STATEMENT OF HOMELESSNESS**

I, _____ (First Name, Last Name), declare under penalty of perjury that I am homeless and that I lack a fixed, regular, and adequate night-time residence.

☐ Self-Declare

☐ The following person can confirm that I am homeless:

Name _____ Phone _____

Address _____

_____

☐ I understand that this information is subject to verification. I certify that the information presented in the above statement(s) is true and correct to the best of my knowledge and belief.

_____ _____

Signature Date