Siskiyou Community Health Center

☐ **GRANTS PASS MEDICAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 471-3455
Fax: (541) 471-1439

☐ **CAVE JUNCTION MEDICAL**
25647 Redwood Highway
Cave Junction, OR 97523
Phone: (541) 592-4111
Fax: (541) 592-3916

☐ **GRANTS PASS DENTAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 479-6393
Fax: (541) 479-6489

CERTIFICATION: Unable to Provide Documentation of Income

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Last Name First Name Date of Birth

I have applied for the Sliding Discount Program with Siskiyou Community Health Center. I understand that I am required to submit documentation to verify my income; however, I do not have any proof of income to submit. My current financial situation is as follows:

____

____

____

I declare that my household income is $_________________________ per month/year (*circle one*). The income reported is received from ____.

I understand this is a federally regulated program and that the information I have supplied above is true to the best of my knowledge, and if I have intentionally misrepresented my financial situation, I am committing fraud.

Signed: ____ Date: ______________________________

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Certification of Information Received

In order for this form to be received as proof of income, a person who knows your situation needs to complete and sign this portion. This person cannot be a family member, a person living in the same household, or an employee of Siskiyou Community Health Center.
I certify that to the best of my knowledge and belief, I know the above statements to be true. I understand that if I know the information is false and I sign this statement, I am contributing to fraud.

Signed: ____ Date: ______________________________

Print Name: ____

Address: ____

Phone: ____ Relationship to the above party: ______________________________