SANDHILLS MEDICAL FOUNDATION, Inc.

Patients Declaring No Income Statement

Date: _____

This is to verify that I, _____ currently do not have any type of income due to _____. I depend on _____ to help with my expenses. They are signing this statement to verify this for my household income verification which is necessary to determine my eligibility for sliding fee services.

I understand that I must report any change in income to SMF for the purpose of updating my sliding fee services.

This form does **NOT** exempt the patient from paying their Dr. visit each time seen and are responsible for paying prior to being seen by the provider.

_____ _____
Patient Signature Date

I hereby state that I, _____ help _____ with her/his monthly household expenses in the amount of $_____, as they do not have any source of income at this present time.

_____ _____
Signature Date