Statement of Zero Income

Applicant Name: _____

Date of Birth: _____

Account #: _____

Instructions: This form is required for applicants reporting **no income during the past 30 days.** Please read carefully and complete all sections.

Certification Statement

☐ **I affirm that neither I nor any member of my household received income from any of the following sources during the last 30 days.**

- Wages from employment (including tips, bonuses, commissions, fees)
- Income from operation of a business
- Rental income from real or personal property
- Interest or dividends from assets
- Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits
- Unemployment, Worker's compensation, or disability payments
- Veteran's benefits
- Public assistance payments
- Periodic allowances such as alimony and child support
- Sales from self-employed resources
- Any other income source not named above.

To help us better understand your current situation and connect you with resources, could you share how you or your household have been managing your living expenses such as — food, housing, and utilities over the past 30 days? (Optional)

_____

_____

_____

☐ **I understand that I must notify Family First Health if my income status changes and submit a new application for the Sliding Fee Discount Program.**

☐ **I certify that all statements on this form are true and accurate to the best of my knowledge. I understand that providing false information may result in denials of the Reduced Fee.**

_____ _____

Applicant/Guarantor's Signature **Date** (mm/dd/yyyy)

FOR OFFICE USE ONLY

Date Received: _____

Processed By: _____ **Date Processed:** _____

Note: Incomplete forms will not be accepted or processed.