pennsylvania
DEPARTMENT OF HEALTH

Effective Date: 10/1/17

Attestation of Income
Specialty Care Programs
Patient Assistance Funds (PAF)

Patient's Name:		
Parent/Guardian's Name (if applicable):		
Address:		
City:	**State:** PA	**Zip:**
Number of people in household (including patient):	**Other/Note:**	

Please check all that apply concerning the patient's taxable household income:

- ☐ My household's taxable income is _____ per ☐ week, ☐ month, ☐ year, see attached supporting documentation.
- ☐ I have no proof of taxable income. I declare my taxable household income is _____ per ☐ week, ☐ month, ☐ year.
- ☐ I have no taxable income to report.

This information is true, complete, and correct to the best of my ability. I understand that if it is later found that I did not qualify for the financial assistance I received that I may be responsible for repayment of any assistance received but was not entitled to. [REVIEW AND CHECK ALL BELOW]

- ☐ I understand that the information provided on this form will only be used for purposes of eligibility determination for financial assistance and will be kept confidential.
- ☐ I understand that I must report income changes to my care coordinator at this clinic within 90 days of the change because it may affect my eligibility for financial assistance.
- ☐ I understand that this form will need to be updated if I request additional assistance.

Applicant's Signature: _____ **Date:** _____

Clinic Use Only:

Clinic Name:		
Verified by:		
Taxable Household Income:	**Per ☐ Week, ☐ Month, ☐ Year**	**Amount of PAF Requested:**
# of people in household (inc. patient):		**Date Provided:** _____/_____/_____
Meets income criteria (300% or below Federal Poverty Level): ☐ Yes or ☐ No		**☐ Supporting documents attached.**