Bartz-Altadonna Community Health Center

Self-Affidavit of Income

Applicants Name: _____

Address: _____

City, State, Zip Code _____

Phone Number: _____

Today's Date: _____

To whom it may concern:

I am providing this affidavit to verify my income as I have no other income documentation available to me. My income is as follows:

(Gross amount) $_____ MONTHLY

(Gross amount) $_____ EVERY 2 WEEKS

(Gross amount) $_____ TWICE A MONTH

(Gross amount) $_____ WEEKLY

I last received this amount on (DATE) _____/_____/_____.

I understand that this information is subject to verification by Bartz-Altadonna Community Health Center. I certify that the information presented in this letter is true and correct to the best of my knowledge.

_____ _____

Signature of person receiving this income Date

For Staff Use Only

Received By:_____ Date: _____

Notes:_____