LA CLINICA INCOME VERIFICATION FORM

1.) Source of Income / Name of Employer _____

(Calculations: choose option A or B)

A.) $ _____ x _____ = _____ x 4.33 = $_____
Hourly rate | Average hours/week | Gross monthly amount

$_____ x _____ = $ _____
Gross monthly amount | months worked | Annual income

-- OR --

B.) $_____ / _____ = $_____
YTD amount | # of months worked that year | Gross monthly amount

$_____ x _____ = $ _____
Gross monthly amount | Months worked | Annual income

2.) Source of Income / Name of Employer _____

(Calculations: choose option A or B)

A.) $ _____ x _____ = _____ x 4.33 = $_____
Hourly rate | Average hours/week | Gross monthly amount

$_____ x _____ = $ _____
Gross monthly amount | months worked | Annual income

-- OR --

B.) $_____ / _____ = $_____
YTD amount | # of months worked that year | Gross monthly amount

$_____ x _____ = $ _____
Gross monthly amount | Months worked | Annual income

3.) Source of Income / Name of Employer _____

(Calculations: choose option A or B)

A.) $ _____ x _____ = _____ x 4.33 = $_____
Hourly rate | Average hours/week | Gross monthly amount

$_____ x _____ = $ _____
Gross monthly amount | months worked | Annual income

-- OR --

B.) $_____ / _____ = $_____
YTD amount | # of months worked that year | Gross monthly amount

$_____ x _____ = $ _____
Gross monthly amount | Months worked | Annual income

TOTAL ANNUAL INCOME $ _____

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that this information may be used to determine my household's eligibility for healthcare grants that will help offset the cost of visits to La Clinica.

_____ _____
Patient / Responsible Party Signature | Date

_____ _____
Patient Name | Staff Initials

Sliding Scale _____ # in Family_____ Chart number _____ Verbal / Verified