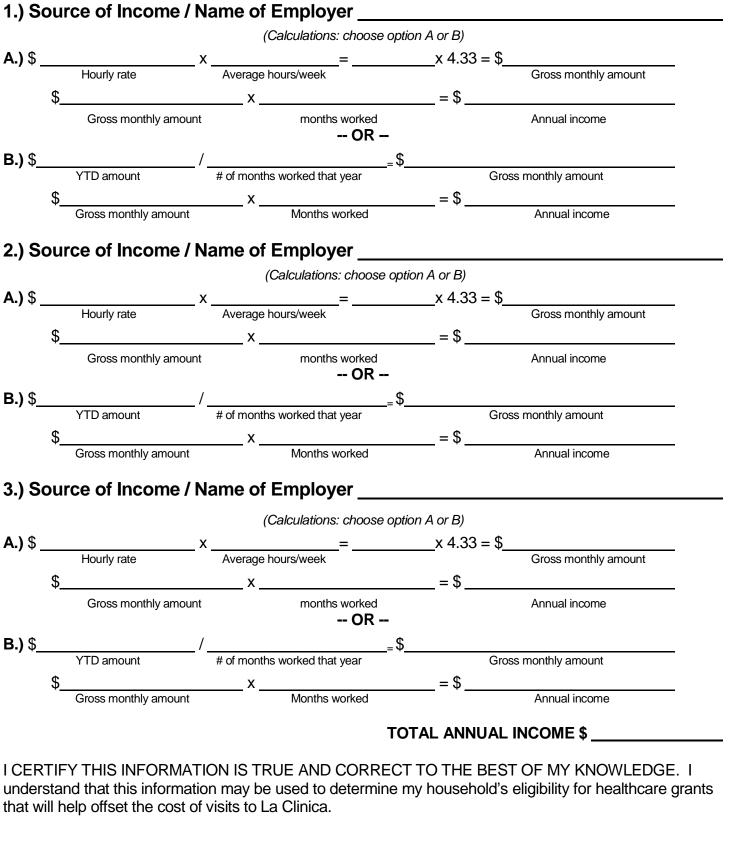
LA CLINICA INCOME VERIFICATION FORM



Patient / Responsible Party Signature			Date	
Patient Name Sliding Scale	_ # in Family	Chart number	Staff Initials	Verbal / Verified