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INCOME STATEMENT

I, _____, declare that I currently have zero
(Patient name)

income. My housing is provided by _____ and his/her
(Name of the person you live with)
relationship to me is _____. The previously named individual

(Check One) does does not provide me with financial support.

If the person named above does provide you with financial support, please provide the following information.

How much money do they provide you: _____

How often do they provide the money (monthly, biweekly, etc.) _____

How long is the financial support supposed to last: _____

In the future, should my financial situation change, I understand that I must notify Affinity Health Center

as soon as possible. By signing this form, I affirm that the above information is an accurate statement of income or assistance being provided and I understand that if I deliberately omit or give false information that I may not be eligible for certain services or the delivery of services could be delayed.

Patient or Guardian Signature

Date

Staff Signature

Date

Patient URN: _____