Will County
Health Department &
Community Health Center

WILL COUNTY COMMUNITY HEALTH CENTER
DECLARATION OF INCOME

PLEASE PRINT:

Last Name: ______________________ First: ___________________ M.I. _______________

Address: ____

City: ________________________ Home Phone: _________________ Gender: Male ☐ Female ☐

Date of Birth: _______________ SSN: _______________________

MM DD YYYY

Housing: Rent Own Doubling Up Homeless Shelter Street Transitional Unknown Other

Race: (circle) White Asian Black/African American Native Hawaiian Pacific Islander
American Indian/Alaskan Native More than one race Other

Ethnicity: (circle) Hispanic Non-Hispanic Veteran: Yes No

Language Barrier: (circle) Yes No Preferred Language: __________________________

Family Size: (Include yourself, spouse, and dependent children under the age of 18) _________

*Income: Yes ☐ No ☐ Income Amount: $ _______ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly ☐

Proof of Income or no income is required by staff to update every 12 months.

Please check all sources of income:

☐ I am employed/my spouse is employed	☐ Unemployed, No Proof of Income Provided
☐ Unemployment Benefits	☐ Food Stamps
☐ Social Security	☐ Alimony
☐ Social Security Disability	☐ Child Support
☐ Supplemental Social Security Income	☐ Pension

Employer's Name: ____

Employer's Address: ____

____

City: ______________________ State: _______ Zip: _________

I hereby attest that the information provided above is complete and true to the best of my knowledge.

_______________________________________ _____________________

Patient Signature Date

_______________________________________ _____________________

Witness Date

Medical Record Number:_________________ Registered by: ___________________

CHC-Policies-Brochures: 6/2019