WILL COUNTY COMMUNITY HEALTH CENTER

VERIFICATION OF INCOME STATEMENT

(SELF-ATTestation)

To Whom It May Concern:

I, __________________________ (name) hereby attest that the total number of individuals in
my family is ____________. Further, I attest that my/our monthly income is: ___________
and my total income from the last calendar year (from all sources) was ____________.

________________________________________ Patient/Parent or guardian

________________________________________ (Date)