Community Health Center of the Black Hills

Self -Attestation Form Total household income (12 month annualized)

Annual Income Before Taxes

Family Size	To	From	To	From	To	From	To	From	To	From
1	$0	$12,760	$12,761	$15,950	$15,951	$19,140	$19,141	$22,330	$22,331	$25,521
2	$0	$17,240	$17,241	$21,550	$21,551	$25,860	$25,861	$30,170	$30,171	$34,481
3	$0	$21,720	$21,721	$27,150	$27,151	$32,580	$32,581	$38,010	$38,011	$43,441
4	$0	$26,200	$26,201	$32,750	$32,751	$39,300	$39,301	$45,850	$45,851	$52,401
5	$0	$30,680	$30,681	$38,350	$38,351	$46,020	$46,021	$53,690	$53,691	$61,361
6	$0	$35,160	$35,161	$43,950	$43,951	$52,740	$52,741	$61,530	$61,531	$70,321
+ 1 Member		$4,480		$5,600		$6,720		$7,840		$8,960

Family Size	To	From	To	From	To	From	To	From	To	From
1	$0	$1,063	$1,064	$1,329	$1,330	$1,595	$1,596	$1,861	$1,862	$2,127
2	$0	$1,437	$1,438	$1,796	$1,797	$2,155	$2,156	$2,514	$2,515	$2,873
3	$0	$1,810	$1,811	$2,263	$2,264	$2,715	$2,716	$3,168	$3,169	$3,620
4	$0	$2,183	$2,184	$2,729	$2,730	$3,275	$3,276	$3,821	$3,822	$4,367
5	$0	$2,557	$2,558	$3,196	$3,197	$3,835	$3,836	$4,474	$4,475	$5,113
6	$0	$2,930	$2,931	$3,663	$3,664	$4,395	$4,396	$5,128	$5,129	$5,860

On this date, I, ____certify that my "household Income"

(the combined income of my current family members, including my parent, guardian, husband, wife, and/or dependent children, if applicable) is _______________________.

I understand that I must provide proof of income to the Community Health Center of the Black Hills with in 10 Days of today's visit or I may be charged additional monies for my visit at a higher income level due to the fact that my income can't be proven.

Signature of Patient ____________________________ Date ______________________________