PLEASE COMPLETE THIS FORM IF YOU HAVE NO OTHER WAY TO DOCUMENT YOUR INCOME OR ANY OTHER MEANS FOR YOUR EMPLOYER TO VERIFY YOUR EMPLOYMENT AND INCOME

ALL INFORMATION YOU PROVIDE IS KEPT CONFIDENTIAL (PRIVATE)!

KNOX COMMUNITY HEALTH CENTER

1361 West Fremont Street ▪ Galesburg, IL 61401 ▪ 309.344.2225 ▪ knoxcountyhealth.org

Patient Employment Verification Form

Patient Name:

Date of Birth: **Today's Date:**

INFORMATION PROVIDED IN THIS FORM IS COLLECTED FROM YOU ONLY TO VERIFY YOUR ELIGIBILITY WHEN PROCESSING THE KNOX COMMUNITY HEALTH CENTER SLIDING FEE SCALE PROGRAM APPLICATION. IT WILL NOT BE PROVIDED TO ANY OTHER AGENCY OR USED FOR ANY OTHER PURPOSE.

Check ALL statements below that apply to your situation:

- ☐ I am currently unemployed.
- ☐ I am paid in cash or non-payroll checks.
- ☐ I do not get payroll checks.
- ☐ I do not get paystubs.
- ☐ I cannot get a letter from my employer establishing my income.
  Explain why: _____
  _____

☐ My employer has completed information and signed in the box below verifying my income.

I AFFIRM THAT THE EMPLOYEE LISTED ABOVE IS EMPLOYED BY THE EMPLOYER LISTED BELOW AND IS PAID A GROSS INCOME (**CIRCLE ONE**: ANNUALLY / PER PAY PERIOD) FROM THIS EMPLOYER OF $_____; AND IS PAID _____ TIMES PER YEAR.

Current Employer Name/Business | **Employer Phone Number**

Current Employer Address

Current Employer Signature | **Date**

Patient Affirmation

I affirm that this information is true to the best of my knowledge and that I have no other way to document income. I hereby give Knox Community Health Center program staff permission to verify any of the above information. I understand that intentionally providing false information may cause me to be ineligible to participate in the Knox Community Health Center Sliding Fee Scale Program.

Signature of Applicant | **Date**