

# HEALING GRACE CLINIC

## -Financial Declaration-

We are here to serve those with limited income and **no** health insurance or other health benefits (including, but not limited to, Well Woman Medicaid, Medicare Part A and hospital only health coverage). The purpose is to make sure that the limited resources available are given to those with the most need.

We will therefore need proof of income to assess if you will qualify to receive care here. One of the following is required *prior to* your first visit and **yearly** thereafter.

- a. **If you filed taxes last year**, provide a complete, signed copy of your Federal Income Tax return, as well as a receipt indicating tax return was accepted. (If you are self-employed, include all schedules.)
- b. **If you did not file taxes last year**, provide a Verification of Non-filing letter from the IRS:
  - a. By calling them at 1-800-829-1040 and follow the prompts. **OR**
  - b. Going to [www.irs.gov](http://www.irs.gov) and click on "Get a Transcript of Your Tax Records" under "Tools". **OR**
  - c. Submitting a mailed request (ask Front Office Staff for copy)

Our income limit is based on the size of your family, which includes all those who live with you (husband, adult children, parents, other family members, boyfriend, etc). The annual income limit is based upon January 1, 2013 allowances. Please circle the number of people living with you:

FAMILY OF	ANNUAL INCOME OF NO MORE THAN
1	\$38,640
2	\$52,260
3	\$65,880
4	\$79,500
5	\$93,120
6	\$106,740

We look forward to partnering with you for your healthcare needs.

Sincerely,

*The Staff at Healing Grace Clinic*

By signing below, I am declaring that I do not carry any health insurance and that my household income level is below the limits as stated above. I understand that if the household income is found to be above what is stated or if I am found to have health insurance, I will be dismissed from care at Healing Grace Clinic.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Birthdate

\_\_\_\_\_

Signature

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

Date

\_\_\_\_\_

Spouse's Name

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

Date

***This declaration will need to be renewed annually.***

*Revised March 2021*