Mother of Mercy Free Medical Clinic
9380 Forestwood Lane Unit B
Manassas, VA 20110
Phone: 703-335-2779 Fax: 703-420-8993
www.ccda.net

Income Verification

Section to be Completed by Patient:

Full Name: _____ Date: _____

Employee Name (Patient or Spouse): _____

Income Verification – This is for the patient who cannot present paystubs documenting income or someone who is paid in cash.

Employer Section: (To be Completed by Employer)

_____
Name (Business / Organization / Individual)

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Name of Supervisor/Manager Telephone Number

Hire Date _____ / _____ / _____

❒ Hourly Rate $_____ Hours worked per week _____
❒ Weekly Rate $_____

I understand that Mother of Mercy Free Medical Clinic can contact me to verify this information. Additionally, I understand that providing false information or information later determined to be false will result in termination of services for the patient.

_____ _____
Signature of Employer and Title Date

_____ _____
Patient Signature Date

Notary Acknowledgement if no Business Card is Provided

Commonwealth of Virginia
County of _____
The foregoing instrument was acknowledged before me this ____ day of _____, 20___, by _____ (name of person providing support).

_____
(Signature of Notary Public) Notary Seal

My comisión expires: _____

CATHOLIC CHARITIES
DIOCESE OF ARLINGTON