



Mother of Mercy Free Medical Clinic

Phone: 703-335-2779

Fax: 703-420-8993

www.cdda.net

9380 Forestwood Lane Unit B
Manassas, VA 20110

13900 Church Hill Drive
Woodbridge, VA 22191

Affidavit of Income – Self Disclose

Section to be Completed by Patient:

Full Name: _____ Date: _____

Section to be Completed by Employed Party (Patient or Spouse):

I, _____, with a
date of birth of _____, single / married, residing at -

verify that my weekly income is an average of _____.

I receive this income by providing services which are paid in cash.

I receive this income from sale of goods including food or material goods paid in cash.

I understand that Mother of Mercy Free Medical Clinic can 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 Employed Party

Date

Patient Signature (Patient is not Employed Party)

Date

Signature of Witness

Date

Notary Acknowledgement

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 comisi3n expires: _____

