



STATEMENT OF INCOME

Client Name _____ Client # _____ As of this date _____

Client is receiving behavioural health services from AllHealth Network. They have indicated the following information to us.

I do not have any source of income or insurance at the present time.

Or

I have limited finances and am requesting assistance.

Annual household income _____

Total # of Individuals in household _____

Client has agreed to notify AllHealth Network when their situation changes in regards to their income, dependents or insurance eligibility. Client understands the fee is based on total household income and number of dependents.

Printed Name of AllHealth Network representative

Signature of AllHealth Network representative

Date