**Living Water Community Clinic**
32345 Constitution Highway, Suite P
Locust Grove, VA 22508
(540) 854-5922

# Cash Income Declaration Form

Patient Name:____________________________________ Date Prepared: ________________

***Please record your daily earnings for the past month.***

| **Week #1**<br>**Date:** | **Amount Earned** | **Week #2**<br>**Date:** | **Amount Earned** |
|---|---|---|---|
| Sunday | | Sunday | |
| Monday | | Monday | |
| Tuesday | | Tuesday | |
| Wednesday | | Wednesday | |
| Thursday | | Thursday | |
| Friday | | Friday | |
| Saturday | | Saturday | |
| TOTAL (Week #1) | | TOTAL (Week #2) | |

| **Week #3**<br>**Date:** | **Amount Earned** | **Week #4**<br>**Date:** | **Amount Earned** |
|---|---|---|---|
| Sunday | | Sunday | |
| Monday | | Monday | |
| Tuesday | | Tuesday | |
| Wednesday | | Wednesday | |
| Thursday | | Thursday | |
| Friday | | Friday | |
| Saturday | | Saturday | |
| TOTAL (Week #3) | | TOTAL (Week #4) | |
| **MONTHLY TOTAL:** | | | |

I certify that the income listed above is correct. If there are changes to my income, I will notify Living Water Community Clinic.

______________________________

(Print Name)

______________________________________ ____________________

(Signature of Patient) (Date)