

**Self Affidavit of Income Letter**

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_

TO: Lyon-Martin Health Services

I am providing this affidavit to verify my income as I have no other income documentation available to me. I receive \$\_\_\_\_\_ (gross amount) and the frequency of pay is \_\_\_\_\_. I last received this amount on \_\_\_\_\_.

I understand that this information is subject to verification by the State of California. I certify that the information presented in this letter is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Patient Signature