



Florida Department of Health in Seminole County  
Florida Breast and Cervical Cancer Early Detection Program  
Self-Declaration Statement  
Effective February 20, 2017

PATIENT'S NAME: \_\_\_\_\_  
Monthly or yearly gross income must be equal to or less than amount listed.

| Family Size | 2017 DOH Scale Monthly Income | 2017 DOH Scale Yearly Income |
|-------------|-------------------------------|------------------------------|
| 1           | \$2,009                       | \$24,119                     |
| 2           | \$2,706                       | \$32,479                     |
| 3           | \$3,403                       | \$40,839                     |
| 4           | \$4,099                       | \$49,199                     |
| 5           | \$4,796                       | \$57,559                     |
| 6           | \$5,493                       | \$65,919                     |
| 7           | \$6,189                       | \$74,279                     |
| 8           | \$6,886                       | \$82,639                     |
| 9           | \$7,583                       | \$90,999                     |
| 10          | \$8,279                       | \$99,359                     |

Please **INITIAL** the following statements:

I DO NOT HAVE MEDICARE \_\_\_\_\_

I DO NOT HAVE MEDICAID \_\_\_\_\_

I DO NOT HAVE PRIVATE HEALTH INSURANCE \_\_\_\_\_

I AM A FLORIDA RESIDENT \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I GIVE MY CONSENT TO THE DEPARTMENT OF HEALTH TO MAKE INQUIRY AND VERIFY THE INFORMATION. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER STATE LAW, IF I HAVE DELIBERATELY SUPPLIED THE WRONG INFORMATION.

I FURTHER UNDERSTAND THAT IF DIAGNOSTIC PROCEDURES ARE REQUIRED FOR MY CARE, I WILL BE EXPECTED TO PROVIDE MORE INFORMATION REGARDING MY INCOME.

SIGNATURE \_\_\_\_\_  
Client

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