Statement of Support

Please complete this form if no income (earned or unearned) is received, and If someone other than your spouse supports you or your family. The person supporting you or your family must fill out this form.

Intentional failure to report correct financial status or incomplete information given in this form may result in denial or termination of the Financial Assistance Program.

I, _____ name of supporter _____ have supported

_____ client's name _____ for this long

(example: 4 months): _____ .

☐ I do ☐ I do not give him/her room and board.

☐ I do give him/her $ _____ ☐ weekly ☐ every two weeks ☐ twice per month ☐ monthly.

My relationship to him/her is _____ . I understand that I am not responsible for his/her medical bills unless I have a legal responsibility to support him/her. I receive income from (job or occupation) _____ .

_____ Signature

_____ Date

_____ Printed Name

_____ Phone

_____ Best Time to Contact

For Office Use (Clinic) Only

Information Verified By: _____ Date: _____

Comments: _____

_____

Eligibility Employee Signature: _____