COMMUNITY HEALTH CENTER
IN COWLEY COUNTY, INC
PO Box 643
Winfield, KS 67156

Community Health Center in Cowley County, Inc.
Westside Clinic - Winfield
Health Care for Everyone

Patient Assistance Program – No Income: Financial Support and Affirmation of Identity Form – (D3)

Date: _____

Patient Name: _____

Please be advised that the above named patient has informed us that he/she currently does not has a stable source of income and that you are supporting him/her financially. Would you please complete the following information to verify that this information is correct so that we may be able to continue the patient's medical/dental/behavioral care?

1. Does this patient live with you? ☐ Yes ☐ No If yes, please verify the address:

_____
Address City State ZIP

2. Do you provide food and clothing for this patient? ☐ Yes ☐ No

3. Patient Assistance Programs require proof of household income. Are you willing to provide that information so that we may be fully able to assist the patient?
☐ Yes ☐ No

Please provide the following information in the event we may need to contact you for further information.

_____
Name

( ) _____ ( ) _____
Home Work

By my signature below, I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request by the CHCCC Patient Assistance Services Program for determining the above named patient's eligibility to participate in the discount program. I agree to inform CHCCC of any changes of condition or circumstance that might affect the above named patient's eligibility to participate in the discount program. Any untruthful or fraudulent information provided may be grounds for denial of assistance to the patient.

_____ _____
Signature Printed Name