Community Health Center in Cowley County, Inc.
Health Care for Everyone

No Income: Financial Support and Affirmation of Identity form (D3)

Patient Name: _____

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

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

_____
Address

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

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 information.

_____
Name

_____ _____
Home Phone Work Phone

With 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 Assistant Services Program for determining the above-named patient's eligibility to participate I the discount program. I agree to inform CHCCC of any changes of condition or circumstances that might affect the above-mentioned 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 of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient