

Verification of No Verifiable Income



This form must be returned to PrairieStar Health Center with the Application for Financial Assistance on or before the service date. This verification expires in ninety (90) days. It is the responsibility of the patient to re-certify before the 90 day expiration. No reminder will be sent.

PATIENT INFORMATION			
LAST NAME	FIRST	MIDDLE	
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		DATE OF BIRTH
BRIEFLY EXPLAIN WHY YOU HAVE NO VERIFIABLE INCOME (UNEMPLOYED WITHOUT BENEFITS, RELOCATION, ETC.), AND HOW YOU ARE RECEIVING SHELTER AND OTHER NECESSITIES.			

I understand that the information provided on this form is correct and subject to verification by PrairieStar Health Center.

PATIENT SIGNATURE	DATE
PATIENT PRINTED NAME	

HAVE SOMEONE WHO CAN VERIFY YOUR INFORMATION SIGN AND DATE THIS SECTION IN FRONT OF A NOTARY.

I hereby state that the above information is true and correct, to the best of my knowledge. I also state that I am not responsible for the above patient's debt.

SIGNATURE OF VERIFYING INDIVIDUAL	DATE
PRINTED NAME	

SIGNATURE OF NOTARY OR PSHC REPRESENTATIVE	DATE
PRINTED NAME	MY COMMISSION EXPIRES
	NOTARY SEAL