

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.			

Upon employment, I understand that I must submit income documentation as soon as possible. I certify that the information provided on this form is correct and subject to verification by PrairieStar Health Center. I understand that false information or omissions will disqualify me from a discount.

PATIENT SIGNATURE	DATE
PATIENT PRINTED NAME	

PSHC REPRESENTATIVE SIGNATURE	DATE
-------------------------------	------