

Verification of No Verifiable Income



This form must be returned to PrairieStar Health Center with the Sliding Fee Scale Application on or before the date of your appointment. 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. | | | |
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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 | |

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