Greater Prince William Community Health Center

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STATEMENT OF SUPPORT

(This information is required only to determine eligibility for our Sliding Fee Scale Discount Program)

APPLICANT SECTION- To be completed by applicant.

I hereby grant Greater Prince William Community Health Center permission to disclose any support provided in order to determine eligibility for the Sliding Fee Discount Program (SFDP).

Applicant Name: ____ Signature: ____ Date: ____________

Statement of Support – The applicant claims he/she has no source of income but receives support (cash and/or non-cash) from one or more individuals (related and/or unrelated), businesses and/or organization must provide completed and signed Statement of Support form from **each** individual, business and/or organization providing cash and/or non-cash support. The Statement of Support expires 30 days after determination of applicant's eligibility for SFDP; a new Statement of Support must be completed and signed by the applicant's next appointment to continue eligibility for the SFDP.

A maximum of three Statements of Support from the same individual, business and/or organization that provides support (cash and/or non-cash) per household will be accepted.

SPONSOR/CARETAKER - This section must be completed by the sponsor/caretaker.

Name (individual / business / organization)	Address	State	Zip Code

Relationship to Applicant (if individual)	Phone Number

Contact Name (if sponsor business or organization)	Contact Phone Number

I verify that the applicant is unable to provide for themselves. I provide support (cash and/or non-cash) to help meet basic living needs of the applicant:

Shelter: YES NO Food: YES NO Clothing: YES NO

Cash: YES NO Amount applicant paid? _________ WEEKLY_____ BI-WEEKLY _____ MONTHLY _____

I understand Greater Prince William Community Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the applicant's eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately.

Completed By (Printed Name and Title): ____

Signature: ____ Date: _______________________

Effective Date: **Immediate**
Approved Date: **06/2010, 06/2011, 05/2013**
Revision Date: **04/ 29/2015**