INCOME VERIFICATION FORM

Patient's Account Number: _____ Patient's DOB: _____

I, _____, on the day of _____
Patient Name (please print) Today's Date

verify that I receive $_____ income per month.

If, you have income that is not reportable by pay stubs or tax returns please check the description:

☐ Odd Jobs ☐ I live off my savings ☐ I live off retirement and/or investments
☐ _____

If your income is zero please explain how you are paying for your housing, food, and other necessities:

How do you eat? _____
Where do you sleep? _____
How do you provide for necessities? _____

My present Living Arrangement:
□ Homeless □ With Family □ With Friends □ Alone □ Shelter/Mission
□ Hospital □ Nursing Home □ Other (please explain) _____

Does anyone provide food or clothing for you? □ Yes □ No
Can anyone claim you on his or her income taxes? □ Yes □ No

Will you, or have you applied for: (Check all that apply)
□ Unemployment □ Employment □ None
□ School □ Medicare or Medicaid

If you receive public assistance, provide verification of the type and amount of assistance you receive. Public assistance may include financial assistance, Medicaid, food stamps, subsidized housing, etc.

I hereby declare that all information provided by me on this form is complete and true to the best of my knowledge and behalf. I agree to notify Bullhook Community Health Center at (406) 395-4305 #5 of any changes in the above information as soon as possible, but within 30 days of my knowledge of the change.

Applicant's signature: _____Date: _____
Expires one year from this date

Applicant's Address: _____

Applicant's Social Security Number: _____/_____/_____

Witness Signature: _____Date:_____
Expires one year from this date

Location: Shared> Forms > Front Desk > Patient Intake forms > SFS APPLICATION FORMS > INCOME VERIFICATION FORM 2019 (Revised 12/31/2018)