PLEASE COMPLETE THIS FORM AND SUBMIT IT WITH YOUR SLIDING FEE SCALE PROGRAM APPLICATION IF YOU STATED "NO" OR "ZERO" INCOME ON YOUR COMPLETED SLIDING FEE SCALE PROGRAM APPLICATION

ALL INFORMATION YOU PROVIDE IS KEPT CONFIDENTIAL (PRIVATE)!

KNOX COMMUNITY HEALTH CENTER

1361 West Fremont Street ▪ Galesburg, IL 61401 ▪ 309.344.2225 ▪ knoxcountyhealth.org

Statement of Support for Applicants with No Income

Patient Name:

Date of Birth: **Today's Date:**

PLEASE CHECK THE BOX BELOW THAT APPLIES TO YOU

Signature of family member, friend, or other is required if:

- ☐ I do not have income to support myself and either live with someone or have someone who supports my daily living expenses and who does not meet the definition for "family size" under this program.
- ☐ I do not have income to support myself and I am homeless or couch-surfing (doubling-up).
- ☐ I do not have income and I am assisted by an agency for housing, food, or other daily needs.
- ☐ I do not have income and I am supported by savings.
- ☐ I do not have income and I am supported solely by Financial Aid (FAFSA).
- ☐ I have income to support myself; but do not file a Federal Tax Return; Profit/Loss Statement Required

Signature of shelter or housing staff is required if:

- ☐ I do not have income to support myself and I am living in a shelter or transitional housing.

I affirm that this information is true to the best of my knowledge. I hereby give Knox Community Health Center program staff permission to verify any of the above information. I understand that intentionally providing false information may cause me to be ineligible to participate in the Knox Community Health Center Sliding Fee Scale Program.

Signature of Applicant **Date**

Signature of Family Member, Friend, or Other **Relationship to You** **Date**

Signature of Shelter or Transitional Housing Staff **Date**