Name of Caregiver: _____Phone _____

Address: _____Relationship to patient: _____

RE: (Patients Name):_____

In order for _____(patient) to qualify for sliding fee benefits we need to have verification of his/her means of support. Patient states that he/she has no income and that you provide support for him/her.

Sincerely,

United Community Health Center
715 W Milwaukee Ave
Storm Lake, IA 50588
Medical phone: (712) 213-0109
Dental phone: (712)213-0179

I _____, attest that I provide (please circle all that applies) food, shelter, clothing, and money. If money please indicate amount $_____ and how often per_____ the assistance is for _____(patient). To my knowledge, he/she has no other income and has no Federal income tax reported.

Caregiver: _____ Date: _____

Patient: _____ Date: _____

UCHC employee:_____ Date:_____

Revised on 10/2021 by CA