Office Use Only

Applicant's Name: _____ Date of Birth: _____

Approved Discount: ❑Slide A ❑Slide B ❑Slide C ❑Slide D ❑Slide E DENIED: ❑Full Pay PRIOR SLIDE?_____

Name of Staff: _____ REASON DENIED: _____

Approved by Signature: _____Date Approved: _____

Family Health Source Verification Checklist		Yes	No
Identification:	Driver's license, Passport, Farmworkers ID or other picture ID		
Prior year tax return:	Tax return provided for Year: _____		
	If Adult Dependents: Need proof of their income or Notarized Verification of Support		
Income:	4 Recent Paystubs if paid weekly or 2 Recent Paystubs if paid bi-weekly		
	Unemployment, Workers Comp, Social Security, SSI, veteran's payment, survivor's benefit, pension/retirement, IRA, etc.		
	Interest, dividends, rental income, royalties, income from estates, trust, alimony, child support, etc.		
If Homeless:	Homeless Shelter Verification and Notarized Verification of Support by person providing support		
If No Social Security #:	Two forms of ID		
	If claiming dependents, we need birth certificates		
If no income:	Notarized Verification of Support by person providing support		
If Self-Employed:	Need Last tax return or Notarized Verification Income Form		
Third Party payor:	Appointment made with enabling services		
	WVHA Health Card Program application given		

FAMILY Health Source

VERIFICATION OF INCOME FORM (VERIFICACIÓN DE INGRESO)

PATIENT SECTION (SECCION DEL PACIENTE):

Please choose all options that apply to you *(Por favor, elija todas las opciones que se apliquen a usted).*

PATIENT'S NAME (NOMBRE DEL PACIENTE):_____ DOB(FECHA NACIMIENTO):_____

ADDRESS(DIRECCIÓN):_____ HOW LONG(CUÁNTO TIEMPO)?____YR/MO

- ❑ I declare that I am presently unemployed and have been unemployed for _____ months. I have/have not applied for unemployment benefits (date applied for benefits_____)
  Declaro que actualmente estoy desempleado y he estado desempleado durante _____ meses. He/no he solicitado beneficios de desempleo (fecha de solicitud de beneficios_____)

- ❑ I declare that I am presently self-employed and receive $_____ per month for the last _____ months and did not file a tax return last year.
  Declaro que actualmente trabajo por cuenta propia, y que recibí $ _____ por mes durante los últimos _____ meses y que no presenté declaración de impuestos el año pasado.

- ❑ I declare that my food and living expenses are provided by (Name and phone number) _____ in the amount of $_____ per month. (Supporter section must be completed)
  Declaro que mi alimentación y mis gastos de vida son proporcionados por (Nombre y número de teléfono) _____ por la cantidad de $ _____ por mes. (La sección de apoyo debe completarse)

PATIENT SIGNATURE (FIRMA DEL PACIENTE): _____DATE(FECHA):_____

SUPPORTER SECTION (SECCIÓN DE QUIEN LE DA EL APOYO)

Supporter's Name (Nombre del apoyador): _____ Phone# (# tel): _____

Address Dirección):_____

I have been providing food and living expenses to, _____, in the amount of $_____ per month. By signing this, I understand under penalty of perjury that any misrepresentation of the information that I provide to NEFHS, Inc DBA Family Health Source is federal fraud punishable by an applicable law.

He estado proporcionando alimentos y gastos de vida a, _____, en la cantidad de $ _____ por mes. Al firmar esto, entiendo bajo pena de perjurio que cualquier mala representación de la información que proporciono a NEFHS, Inc. DBA Family Health Source es un fraude federal punible por las leyes aplicables.

SUPPORTER SIGNATURE (FIRMA DEL APOYANTE):_____DATE(FECHA):_____

STATE OF FLORIDA, COUNTY OF VOLUSIA (Notary Seal)

Sworn before me this _____ day of _____, 20___, by _____

Signature of Notary Public-State of Florida: _____

Name of Notary typed, printed, or stamped:_____

_____Personally Known OR _____Produce Identification Type of ID:_____

Scan to Patient Chart under Slide Fee Created: 2/26/2019