DRAGON CARE
GOOD SAMARITAN HEALTH & WELLNESS CENTER

# Income Verification Form

**Please complete the information below if you have limited or no income currently.**

Patient Name: _____ Guardian Name: _____

SSN (Optional): _____ Date of Birth: _____

1. What is your current monthly income (including child support, SSI, disability, etc.)?

   _____
2. Are you currently working? Where? _____
3. If not, how long have you been out of work and why? _____

   _____
4. Are you interested in employment resources? _____
5. Who do you live with (a friend, family, alone, etc.)? _____
6. What is your current address? _____
7. Do you provide any services in return for this living arrangement (chores, yardwork, etc.)? Please List:

   _____

   _____

Other comments: _____

_____

_____

**Please provide contact information for two people who can verify this information.**

1. Name: _____ 2. Name: _____

   Address: _____ Address: _____

   _____ _____

   Phone Number: _____ Phone Number: _____

   Relationship: _____ Relationship: _____

*Good Samaritan Health and Wellness Center reserves the right to verify this information. If this verification reveals that the above information is incorrect, the patient may lose privileges at Good Samaritan Health and Wellness Center.*

**APPLICANTS/RECIEPIENTS MUST READ THE FOLLOWING AND SIGN BELOW:** *I certify that all the above information is true and accurate. I understand that this information is to be used to determine eligibility for Financial Assistance.*

Patient Name (Printed): _____

Patient/Guardian Signature: _____

Date: _____