



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 income or 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_____, for _____ (patient) and that to my knowledge he/she has no income and has not file Federal income tax.

Caregiver: _____ Date: _____

Patient: _____ Date: _____

UHC employee: _____ Date: _____