Certification of Zero Income

Health and Human Services Division
Indigent Health Care

Client Name: _____ Client DOB: _____

Effective Date: _____ Date of First Visit: _____

Choose One:

☐ Client has no proof of income.

☐ Currently, I have no income of any kind and, while I am actively seeking employment, there is no definitive job offer at this time.

☐ Currently, I have no income of any kind and will not be seeking employment at this time.

Household Information: Enter information on all members residing in your household.

Name	Relationship to Client	Date of Birth	Income

The following sources of funds pay for Client's basic necessities including: food, shelter, clothing, transportation, and medical care. (Please list name(s) and phone number(s) of person/organization providing basic needs.)

_____

_____

Please note last date of employment and any comments you feel are needed for your application:

_____

_____

_____

I certify that the information provided in this form is accurate and true. I understand that if I willfully withheld and/or gave false information on purpose for my gain, I may be dismissed as a patient of Lakeland Volunteers in Medicine. I also understand that Lakeland Volunteers in Medicine may verify any/all information provided on this form.

Signature of Client: _____ Date: _____