HEALTH CARE

Income Verification Form

This form should only be used when the applicant for Financial Assistance lists no income.

All fields on this form must be completed for the form to be valid.

Applicant Name:	Applicant Current Address:

Applicant Income Verification
I, _________________________________, certify that I have no earned or unearned income. I give McLaren Health Care permission to verify this statement. I understand that if McLaren Health Care finds that I have earned or unearned income, I will be disqualified from receiving financial assistance. I am currently being supported by (list how you are meeting basic expenses, food, clothing, shelter, including the names of all individuals providing support): ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ I understand that a representative from McLaren Health Care may contact the individuals listed above to verify the information provided.

Signature
Applicant Signature: ____ Printed Name: ____ Date: ____

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