Rockbridge Area
Health Center

STATEMENT OF SUPPORT

(This information is required only to determine eligibility for our Sliding Fee Scale Discount Program)

Anyone applying for financial assistance with no source of income must complete this form. It must also be signed by the person providing the financial support and turned in along with the completed financial assistance application. The Statement of Support expires after 6 months after determination of applicant's eligibility for SFDP.

To be completed by the applicant:

I, _____ DOB: _____, declare that I have no employment and do not have income of any kind.

"Family/Household" includes spouse and dependents:

_____

Applicant Signature: _____ Date signed: _____

To be completed by the person(s) providing the financial support:

Name of person(s)/business/organization providing financial assistance (please print):

_____

Relationship to Applicant (if individual): _____

Address: _____State_____ZipCode_____

Phone: _____

Contact Name (if business): _____ Phone Number_____

I verify that the applicant is unable to provide for themselves. I provide support (cash and/or non-cash) to help meet the needs of the applicant (check which applies):

Cash: YES NO Amount paid?_____WEEKLY_____ BI-WEEKLY_____ MONTHLY____

Shelter: YES NO Food: YES NO Clothing: YES NO Transportation: YES NO

I understand Rockbridge Area Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the applicant's eligibility for SFDP discounts to be revoked and the full balance of the account(s) restored and payable immediately.

Signature of person providing financial support:

_____ Date signed: _____

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