



### HOUSING / INCOME VERIFICATION

I, \_\_\_\_\_ receive \$ \_\_\_\_\_ in monthly income.

I certify to the best of my knowledge that this information provided to Fetter Health Care Network (FHCN), is true and accurate. I understand that I am to immediately report any and all changes in income to the staff of Fetter Health Care Network and that falsification or failure to report income information may lead to my inability to receive medical services at Fetter Health Care Network.

#### Housing Information

Are you residing in a Shelter or Housing Program? Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes:**

Name of Shelter/Program: \_\_\_\_\_

Address of Shelter/Program: \_\_\_\_\_

**If No:**

Address \_\_\_\_\_

Number of Children \_\_\_\_\_

Number of Adults \_\_\_\_\_

\_\_\_\_\_  
Consumer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Mgr. / Employer / Head of Household

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/FHCN Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Shelter or Housing Notary Approval

\_\_\_\_\_  
Date