ICNARelief
SHIFA CLINIC, SC

# No Income Form

**NOTE: USE THIS FORM ONLY IF NO ONE IN THE HOUSEHOLD HAS INCOME**

**Patient must complete SECTION 1 - Person helping the patient must complete SECTION 2**
**Completed form must be submitted with Welvista application package**

## SECTION 1 - Patient Information (All information required)

By signing, I verify that **I, OR NO ONE LIVING IN MY HOUSE** have no income.

If I, or anyone in my house receives Food Stamps and/or help from the Housing Authority (HUD**), I HAVE ATTACHED A CURRENT STATEMENT FROM EACH ORGANIZATION.**

Patient Name (Please Print):_____

Patient Signature:_____Date: _____

## SECTION 2 - Person helping patient (All sections must be completed, including dollar amounts.) We need to know how patient is living day to day (housing, food, and utilities).

By my signature, I verify the above patient's current housing situation, that all information is true, and that no work or services are given in exchange for support. THE PERSON HELPING THE PATIENT CANNOT LIVE IN THE SAME HOUSE AS THE PATIENT.

Name of person helping or verifying patient living situation: _____
(Printed name)

Please list the dollar amount you have paid/given in the last 30 days for each item below that applies:

$_____House/Rent (If answer is $0 state why):_____
$_____Food (If answer is $0 state why):_____
$_____Utilities (If answer is $0 state why): _____

$_____Total amount given to patient per month

_____Date:_____
(Signature of person helping or verifying patient living situation)

**OR** – Patient has no one over age 18 to vouch for their current living situation:

_____Date: _____
(Patient Advocate/Case Manager)

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