Lone ★ Star
*Circle of Care*

## INCOME VERIFICATION FOR NON-EMPLOYED PATIENTS

Date: _____

Name: _____

Address:_____

_____

Phone: _____

Re:_____

I, _____, am currently financially responsible for the living expenses of _____.

The above named Patient is currently unemployed and is currently not meeting their own financial living expenses. They currently have a monthly income of $0.00.

If you are responsible for additional financial expenses, please list:

_____

_____

_____
Printed name

_____ _____
Signature Date

_____ _____
LSCC Representative Date

_____
LSCC Clinic Location