Harrisonburg Community Health Center

1380 Little Sorrell Drive, Suite 100
Harrisonburg, Virginia 22801
540.433.4913
Fax 540.433.4915
www.hburgchc.org

STATEMENT OF SUPPORT

APPLICANT SECTION (*to be completed by applicant*)

I hereby grant Harrisonburg Community Health Center permission to disclose any support provided in order to determine eligibility for the Sliding Fee Discount Program.

Applicant Name: _____ Date: _____

Signature: _____

SPONSOR/CARETAKER *(this section must be completed by the sponsor/caretaker)*

_____ _____
Name (individual/business/organization) Address State Zip code

_____ _____
Relationship to Applicant Phone Number

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

☐ **Shelter**	**$ _____**	**monthly**	**Bi-weekly**	**Weekly**
☐ **Food**	**$ _____**	**monthly**	**Bi-weekly**	**Weekly**
☐ **Bills**	**$ _____**	**monthly**	**Bi-weekly**	**Weekly**
☐ **Cash**	**$ _____**	**monthly**	**Bi-weekly**	**Weekly**
☐ **Other**	**$ _____**	**monthly**	**Bi-weekly**	**Weekly**

I understand Harrisonburg Community Health Center may contact me to verify this information. Furthermore, I understand that if the information provided is found to be incomplete or fraudulent the applicant will be removed from the Sliding Fee Discount Program PERMANENTLY.

Completed By: _____

Signature: _____ Date: _____

Effective Date:
Revised: