



## LOWER LIGHTS CHRISTIAN HEALTH CENTER

### NO INCOME VERIFICATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

By signing below I certify that the above named patient does not have any form of income from any sources.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Position: \_\_\_\_\_

I agree to notify Lower Lights Christian Health Center if there is a change in my income status.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_