Regional Medical Center
Greenfield Medical Center
Pike Medical Center

ZERO INCOME VERIFICATION STATEMENTS

PLEASE NOTE: THIS FORM APPLIES ONLY IF YOU AND YOUR HOUSEHOLD HAD NO INCOME THE THREE MONTHS PRIOR TO THE DATE OF SERVICE.

SECTION I: (Completed by the patient)

I, ____________________________________ have had no income from ____________ to
(MM/YY)

____________ three months prior to the date of service.
(MM/YY)

Signature: ____ Date: _______________

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SECTION II. (Completed by the supporter/friend)

I, ____________________________________ have provided means of temporary food
(Supporter/Friend)

and/or shelter during the time of ___________ to ___________. If you have any questions,
(MM/YY) (MM/YY)

Please call me at _________________________.
(Phone #)

Signature: ____ Date: _______________