MIAMI BEACH COMMUNITY HEALTH CENTER, INC.

PATIENT VERIFICATION OF INCOME

Date:

This form certifies that ______________________________ ______________________
PRINT FULL NAME SOCIAL SECURITY NUMBER

____________________, income information has been verified and found to be accurate.
DATE OF BIRTH

Items Verified Includes:

_________Picture ID

_________Unemployment Letter

_________Food Stamp Card or Letter

_________Last Paycheck Stub

_________Last Income Tax Return

_________Notarized Letter

_________Other

_________Foot Print

_________Birth Certificate

_________Social Security Letter (SSI)

_________Medicaid

_________Medicare

_________Passport

EXPIRATION DATE _______/________/_________

Patient Must Bring:

___________Patient ID

___________Proof of Income

___________Notarized Letter from Job

___________ H.R.S. Public Assistance

___________Birth Certificate

___________Foot Print

We have found, after careful review that client has no income. Patient acknowledges and understands that failure to provide the requested documentation will result in an increase of classification to "Full Pay".

______________________________ ______________________________

Patient Signature **Interviewer Signature**