ACHN Clinic
4431 Brookfield Corporate Drive, Unit F
Chantilly, VA 20151
(703) 542-3366 – Office
(888) 965-5824 – Fax
www.achnhealth.org

LETTER OF FINANCIAL SUPPORT

Patient Name: _____

Date of Birth: _____

Date: _____

I, _____, support _____ financially by providing shelter, money, groceries, and/or other basic necessities. I expect to provide this support until _____.

By signing this form, I understand I may be financially liable for all services rendered in false or if misleading information is intentionally given. I agree to notify the clinic about any changes in the support I am providing within 30 days of the change.

Signature: _____

Name: _____

Address: _____

_____

Phone: _____

Relationship to patient: _____

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ZERO INCOME STATMENT

Patient Name: _____

Date of Birth: _____

Date: _____

I am signing this form to declare that I currently **DO NOT HAVE ANY INCOME** from any source. I receive financial support from:

☐ **Family, friend, or outside source** (Please have your supporter fill out the Letter of Support)

☐ **Receive state benefits. This includes but is not limited to SNAP, SSI, Disability, etc.** (You must submit recent proof of receiving these benefits)

☐ **Other** (You must submit proof or a letter explaining)

I agree to notify the clinic about any changes in my income within 30 days of the change. I understand that by completing, signing, and dating this form, I declare I have no household income and that the information I am providing is correct. I understand that providing false information may result in denial or termination of services from ACHN Clinic.

Signature of Patient _____

Patient's Telephone Number _____