Indigent Health Care Program
Of Marion County Hospital District
1113 N. Walcott St., Suite B
Jefferson, Texas 75657
(903) 665-2161 Fax (903) 665-8011

ASSISTANCE VERIFICATION STATEMENT

The below stated person(s) has informed the Marion County Indigent Health Care office that you help. This must be verified for the applicant's application to be complete. Please fill out the form below. Should you have any questions, contact the office at 903-665-2161

Client Name: ____

Client Address____

Money that is given directly to a County Indigent Health Care household member, regardless of how it is supposed to be used, is counted as income and will affect eligibility. Money that is paid directly to vendors is not counted against household income amount. Please fill out all that applies to the assistance you contribute for the applicant.

I, ____, provide assistance to
____ by(complete all that apply):

By:
Giving money (contributions/cash gifts) directly to person(s) listed above for personal use.

Date____________ Amount__________ Date___________ Amount___________

Date____________ Amount__________ Date___________ Amount___________

Paying bills directly to: (name vendor or type of bill)
____
____

In-Kind assistance (ex. food, transportation, housing, personal items, etc.)
____
____

Loans
Date_________ Amount_________ Date________ Amount__________

When is the loan to be repaid? ______________________

Do you plan to make any or all of the above provisions on a monthly basis? ________Yes ______No.
If No, how long do you plan to give assistance? ____

I understand that providing false information can result in a fine or jail term. I certify that the above information is correct.

____ ____________________
Signature Date

____ ____________________
Mailing Address Daytime Phone No.

The foregoing instrument was acknowledged before me on _______________________________, 20___

(seal)

____
Notary Public, State of Texas
Marion County, Texas
My Commission Expires:________________________