HARRIS COUNTY HOSPITAL DISTRICT
PATIENT ELIGIBILITY SERVICES
RESIDENCE VERIFICATION FORM

Client Name and Address:

____

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Date:______________________________________

Eligibility Center: _____________________________

Interviewer: __________________________________

The person listed above has told us that you are not related to them but are familiar with their family. To help us correctly evaluate the household's situation, we need your assistance.

Please complete the information below and return it to:

(stamp center name and address here)

Please return it as soon as possible, but no later than ____________. Your help is greatly appreciated.

Please list all the persons living in the home, including the client named on the front of this form.

Name	Relationship to Client	Name of Employer
Client		

I can verify the above information because I am: (check one)

_____ A neighbor _____ A school official _____ A friend
_____ A clergyperson _____ An employer _____ A child care provider _____ Other (explain): _____________________________

How long have you known the family? _____ years, _____ months, or _____ weeks.

Signature: _______________________________

Please print your name, address and telephone number below:

Name: ________________________________

Address: ______________________________

____

Phone: ________________________________

Form 3000 (7/30/02)