



**HARRIS COUNTY HOSPITAL DISTRICT  
 PATIENT ELIGIBILITY SERVICES  
 RESIDENCE VERIFICATION FORM**

Client Name and Address:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 landlord  
 \_\_\_\_\_ 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: \_\_\_\_\_