ADENA

Regional Medical Center
Greenfield Medical Center
Pike Medical Center

ZERO INCOME VERIFICATION STATEMENTS

PLEASE NOTE: THIS FORM APPLIES ONLY IF YOU AND YOUR HOUSEHOLD HAD NO INCOME THE THREE MONTHS PRIOR TO THE DATE OF SERVICE.

SECTION I: (Completed by the patient)

I, _____ have had no income from _____to
(MM/YY)

_____ three months prior to the date of service.
(MM/YY)

Signature: _____ Date: _____

_ _

SECTION II. (Completed by the supporter/friend)

I, _____ have provided means of temporary food
(Supporter/Friend)

and/or shelter during the time of _____ to _____. If you have any questions,
(MM/YY) (MM/YY)

Please call me at _____.
(Phone #)

Signature: _____ Date: _____