



"A NON-PROFIT ORGANIZATION SINCE 1979"

9862 Chapman Ave. Garden Grove, CA 92841

Tel: (714) 620-7001 – Fax: (714) 620-7091

www.southlandintegrated.org | info@southlandintegrated.org

SUPPORTER'S AFFIDAVIT STATEMENT

Please complete the information listed below only if you have no other way to provide proof of your income. All information below must be answered. Failure to complete this form may result in denial of your Sliding Fee Scale Application.

Patient's Name: _____ Date of Birth: _____

Supporter's Name: _____ Relationship to Patient: _____

Supporter's Phone Number: _____

Supporter's Email Address: _____

Supporter's Address: _____
[Street] [City] [Zip code]

I declare that I am supporting this patient with financial expenses indicated below from _____ to _____.

Allowances:

Do you provide this individual a monthly allowance?

☐ Yes, how much? _____

☐ No

Rent:

Do you charge this individual a monthly rent?

☐ Yes, how much? _____

☐ No

Food:

Do you charge this individual for monthly food costs?

☐ Yes, how much? _____

☐ No

Utilities:

Do you pay for this individual's monthly utilities?

☐ Yes, how much? _____

☐ No, who pays? _____

Cell Phone Bill:

Do you pay for this individual's monthly cell phone bill?

☐ Yes, how much? _____

☐ No, who pays? _____



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Car Gas:

Do you pay for this individual's monthly car gas?

☐ Yes, how much? _____

☐ No, who pays? _____

Car Insurance:

Do you pay for this individual's monthly car insurance?

☐ Yes, how much? _____

☐ No, who pays? _____

Medical Health Insurance:

Do you pay for this individual's monthly medical health insurance?

☐ Yes, how much? _____

☐ No, who pays? _____

Other Monthly Expenses:

Please list out other expenses and amounts that are not listed above:

Other Expense: _____

Amount: _____

Other Expense: _____

Amount: _____

Other Expense: _____

Amount: _____

Other Expense: _____

Amount: _____

Supporter's Declaration:

- I declare under penalty of perjury that the answers I have provided in this form are correct and true to the best of my knowledge.
- I understand that the statements on this form are subject to verification and investigation and that my signature on this form provide Southland the authorization for such an investigation.
- I realize that if I deliberately make false statements or withhold information in an unlawful manner, the individual that I am supporting may lose Sliding Fee Scale benefits and/or be prosecuted. I understand that any benefits that the patient receives fraudulently may be subject to collection by Southland Integrated Services, Inc.

Supporter's Signature: _____

Date: _____