FAMILY MEDICINE HEALTH CENTER

Supplemental Contribution Statement
For FMHC Financial Assistance Programs

This form is to be COMPLETED and SIGNED by the person helping the applicant. Additional Supplemental Contribution Statements are required for each individual who provides assistance to the applicant.

Applicant's Full Name: _____ Phone #: (___) _____-_____

☐ I provide the Applicant a place to live, at no cost to the applicant, which is valued at $_____ per month.
*****Please note, value of housing should reflect the fair market value for the space provided to the applicant.**

☐ I provide the Applicant with financial assistance (cash, check etc.) to be used applied to housing expenses in the monthly amount of $ _____.
*****Please note, value of housing should reflect the fair market value for the space provided to the applicant.**

☐ I provide groceries or financial assistance (cash, check etc.) to be applied to grocery expenses in the monthly amount of $_____.

☐ I provide car payments or financial assistance (cash, check etc.) to be applied to car payments in the monthly amount of $ _____.

☐ I provide credit card payments or financial assistance (cash, check etc.) to be applied to credit card payments in the monthly amount of $ _____.

☐ I provide utility payments or financial assistance (cash, check etc.) to be applied to monthly utility payments as follows;

Power: $_____ Gas: $_____ Water: $_____ Trash: $_____ Sewer: $_____

☐ I provide phone payments or financial assistance (cash, check etc.) to be applied to phone payments in the monthly amount of $ _____.

☐ I provide health care payments or financial assistance (cash, check etc.) to be applied to health care payments as follows;

Hospital: $_____ Dental: $_____ Prescription: $_____ Primary Care: $_____

☐ I provide miscellaneous financial assistance (cash, check etc.) to the applicant in the monthly amount of $ _____.

☐ I provide personal hygiene items or financial assistance (cash, check etc.) to be applied to personal hygiene items in the monthly amount of $ _____.

☐ I provide _____ or financial assistance (cash, check etc.) to be applied to _____ in the monthly amount of $ _____.

I hereby certify that the information listed above is true and correct. I understand that the Applicant is applying for financial assistance through the FMHC Financial Assistance Program and that falsifying information could lead to financial consequences for the Applicant including termination of previous and future financial assistance.

Printed Name: _____

Signature: _____

Date: _____ Phone #: (____) _____-_____

Address: _____

Relationship to the Applicant: _____