IN-KIND INCOME AFFIDAVIT

Please complete if you are providing support to an applicant for My Health LA (MHLA) program

Patient Name: _____
Member ID: _____

Dear _____

Your name has been given to us as a provider of in-kind income for the above-mentioned person(s)

Please complete the brief questionnaire and return it to my attention as soon as possible using the enclosed, self-addressed envelope.

Thank you in advance for your cooperation.
Very truly yours,

_____ _____
California Enrollment Counselor Date

Please complete: Person Providing Support:

Last Name:	First Name:			Phone: ( )	
Street Address:			City:	State:	Zip:
I am providing: (Check all that apply)	Utilities ☐	Food ☐	Housing ☐	Cash Amount ☐ Please specify amount and frequency:_____	
I expect to provide items (for how long?)				Please choose one: Earned ☐ Free ☐	
Is applicant residing with provider? Yes ☐ No ☐					
I declare the answers given are true and correct to the best of my knowledge. I understand the information provided will be used to screen the applicant for eligibility to various Federal, State, and County Programs. I understand that I will not be held responsible for any fees for medical services received by the applicant.					
_____ Signature of person providing support				_____ Date	

Applicant Receiving Support:

I declare the answers given are true and correct to the best of my knowledge. The information provided will be used to screen for eligibility to various Federal, State, and County Programs. I understand that if the information is found to be false, I will be held responsible for the full amount of fees for medical services received.
_____ Signature of Applicant _____ Date