

**COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES  
AFFIDAVIT OF RESIDENCY FOR PATIENTS PRESENTING AS HOMELESS**

Patient: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Medical Record No.: \_\_\_\_\_ Service Date: \_\_\_\_\_

I am a homeless resident of the County of Los Angeles. I intend to remain in Los Angeles County and do not maintain a home in another state/country. I cannot provide proof of my current address. I certify through my signature that the statement given below is true and correct. I currently live at: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact for medical reasons:

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Signature: \_\_\_\_\_  
Patient or Responsible Relative Date

Any person who signs this statement and who willfully states as true any material matter which he knows to be false is subject to the penalties prescribed for perjury in the penal code by the State of California SEC 11054 of the W. & I. Code.

\_\_\_\_\_  
Witness Signature Telephone Number Date

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Date