Clear Form Print Form

COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES
VERIFICATION OF RESIDENCY FOR IMPACTED HOSPITAL PROGRAM

Patient: _____Facility Name: _____

Medical Record No.: _____Service Date: _____

I am a resident of the County of Los Angeles. I intend to remain in Los Angeles County and 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:

Address required unless homeless

_____
Street Number Street Name

_____
City State Zip Code

_____
County Telephone

Or, I am homeless and reside in Los Angeles County ☐

Emergency Contact:

Name:_____Relationship_____

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