



BRAZORIA COUNTY INDIGENT HEALTH CARE PROGRAM

MANAGEMENT VERIFICATION FORM

This form must be completed by any person helping to support the below mentioned applicant. Please complete all information requested below, including the applicant's name and address.

Applicant's Name: _____

Applicant's Address: _____

1. Are you related to the applicant, if yes, how? _____

2. Does this person live with you? _____ Yes _____ No How long? _____

3. Does he/she pay rent? _____ Yes _____ No How Much? _____

Utilities? _____ Yes _____ No How Much? _____

Phone? _____ Yes _____ No How Much? _____

4. If you have paid any bills for this applicant, please state the type of bill, to whom it was paid, and the date:

5. Have you loaned or given (CHECK ONE) any money to the client? _____ Yes _____ No

How Much? _____ When? _____ Why? _____

6. Does the applicant purchase and prepare food separately from you? _____ Yes No _____

7. Is the applicant working? _____ Yes _____ No Where? _____

8. Have you assisted the applicant in any other way? Please state here, how: _____

Printed Name Signature Date

Address Phone Number

THIS FORM MUST BE NOTARIZED

State of Texas
County of Brazoria County

Before me, a notary public, on this day personally appeared _____.
Known to me to be the person whose name is subscribed to the foregoing instrument(s), and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20_____.

Notary Public My Commission Expires