FHP Verification of Income from Regular Contributions

❑ 2189 Cleveland St, Ste 230, Clearwater, FL 33765 Fax: (727) 464-8428

❑ 647 First Avenue North, St. Petersburg, FL 33701 Fax: (727) 582-7912

Attention: _____ Date: _____

_____

_____

We are required by law to verify regular contributions (monetary or not) made to the person that has provided authorization below, in order to determine their eligibility for program assistance. We would greatly appreciate your prompt return of this letter. Please return this information to the address or fax number checked above. If you have any questions, please call:

_____ _____

FHP Case Manager Name Phone Number

We are requesting information concerning the applicant named below:

Name: _____ Social Security #: _____

Street Address: _____ Date of Birth: _____

(Head of Household: _____)

Authorization:

I herby authorize the release of requested information to be used for the sole purpose of determining eligibility for program assistance.

_____

Signature of Applicant Print Name Date

Please provide information about anticipated regular contributions during the next 12 months:

Type of Contribution(s): _____

Amount: $_____ Frequency of contribution (Daily, Wk, Mo, Yr): _____

Expected termination date of contributions: _____

Anticipated total contributions over the next 12 months: $ _____

By signing below, I certify that this information is truthful.

Print Name: _____ Signature: _____

Address: _____ Phone: _____

_____ Date: _____