



2800 West 95th Street  
Evergreen Park, Illinois 60805  
708.422.6200  
www.lcmh.org

## PROOF OF RESIDENCY FOR FINANCIAL ASSISTANCE

DATE \_\_\_\_\_

I, \_\_\_\_\_ do hereby swear that  
\_\_\_\_\_ resides in my home/apartment free  
of charge and provide his/her food and everyday necessities at this time.

I have been caring for him/her since \_\_\_\_\_ to date.

Patient Name \_\_\_\_\_

Patient Visit Number \_\_\_\_\_

**\*If you live with someone and no rent is paid please fill out this form and attach it to the Charity Care**

**Application.**

NOTARY HERE

\_\_\_\_\_  
PRINT NAME DATE

\_\_\_\_\_  
SIGN NAME DATE

\_\_\_\_\_  
WITNESS DATE

\_\_\_\_\_  
HOSPITAL REPRESENTATIVE DATE