AFFIDAVIT OF SUPPORT

Please complete if you are providing support to an applicant for San Francisco City and County Health Programs

Individuals who are providing housing on behalf of an applicant for San Francisco City and County health programs ***may be contacted by phone*** *by a representative of the City and County of San Francisco to confirm that the information is true and correct.* ***Failure to respond to calls from representatives and to confirm the accuracy of the information on the form will result in a review of the participant's eligibility.*** *This information is required to confirm the applicant's San Francisco residency status only and will not be reported to the IRS or federal immigration authorities.*

Please Complete: Person Providing Support:

Last Name:		First Name:		Phone: ( )	
Street Address:			City:	State:	Zip:
I am providing: (Check all that apply)	Cash: ☐	Food/Clothing : ☐	Housing: ☐	Other: _____	
I expect to provide these items (for how long?)					
I declare the answers given are true and correct to the best of my knowledge. I understand the information provided will be used to screen the applicant for eligibility to various Federal, State, and County Programs. I understand that I will not be held responsible for any fees for medical services received by the applicant.					
_____ Signature of Person Providing Support				Date	

Applicant Receiving Support:

I declare the answers given are true and correct to the best of my knowledge. I understand the information provided will be used to screen for eligibility to various Federal, State, and County Programs. I understand that if the information is found to be false, I will be held responsible for the full amount of fees for medical services received.
_____ Signature of Applicant Date