Declaration of Support

Date _____

Head of Household _____

Names of Applicants

_____ _____

_____ _____

_____ _____

_____ _____

To help determine your family's eligibility, please have the person that provides you support complete the information below about themselves.

THE FOLLOWING SHOULD BE COMPLETED BY THE PERSON PROVIDING SUPPORT

To help determine if the applicant(s) listed above are eligible for health insurance programs, please provide the required information below about yourself. Thank you.

Name _____ Phone _____

Your relationship to the applicant(s) _____

Address _____

City _____ State _____ Zip Code _____

I declare that I provide support for the following persons:

_____ _____

_____ _____

_____ _____

_____ _____

residing at (address) _____

I provide the following support (check all that apply):

- ☐ Housing
- ☐ Cash: $ _____
- ☐ Money for medical needs
- ☐ Clothing
- ☐ Food
- ☐ Personal spending money
- ☐ Other (please specify) _____

Signature _____ Date _____

Head of Household: _____ Head of Household Phone: _____ Member ID: _____

USE KEY | MDC | CHP | ALL COUNTIES