Colorado Residency Affidavit

Denver Health and Hospital Authority

MY NAME IS: _____

Provide the Full Legal Name of the Person Providing Residence for the CICP Applicant

I RESIDE AT: _____ _____

Street Address Apt. #

_____ / _____ / _____ / _____

City State Zip County

MY PHONE NUMBERS ARE: _____ / _____ / _____

Home Cell Work

THE NAME OF THE CICP APPLICANT ("Applicant") is: _____

(Check the one that applies)

- ☐ **Applicant uses my address as a mailing address, but does not live with me.**
- ☐ **Applicant uses my residence to keep his/her belongings and/or occasionally to shower, have a meal, etc.., but does not live with me.**
- ☐ **Applicant occasionally (twice per week or less) stays at my residence.**
- ☐ **Applicant resides with me, but is NOT included as a borrower on my mortgage or included as a tenant on my lease. Applicant pays a portion of my monthly household expenses.**
- ☐ **Applicant resides with me, but is NOT included as a borrower on my mortgage or included as a tenant on my lease. Applicant is not required to pay any portion of my monthly household expenses.**

I HEREBY AGREE to provide Denver Health with documentation of my residency at the above address.

I HEREBY AUTHORIZE Denver Health to verify the accuracy of the information provided in this Affidavit through independent sources.

I HEREBY CERTIFY THAT THE INFORMATION STATED ABOVE IS TRUE AND CORRECT. I UNDERSTAND THAT, IF ANY OF THE INFORMATION IS KNOWN TO ME TO BE FALSE, I MAY BE COMMITTING A CRIME FOR PROVIDING FALSE INFORMATION TO THE HOSPITAL AND WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW.

_____ _____

Signature of Person Providing Residence **Date**

_____ _____

Signature of CICP Applicant **Date**

_____ _____

Signature of Enrollment Specialist **Date**