

Denver County 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: _____ Apt. # _____
Street Address
_____/_____/_____/_____
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