MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

Request for Domicile Verification

This form must be completed by a non-relative who does not live with the client

Client Name: _____ Case: #_____

Address: _____
_____
_____

The person listed above has informed us that you are not related to them, however you are familiar with their family status. To help us correctly evaluate the household's situation, we need your assistance.

Please list all persons living in the home, including the client listed on the top of this form.

	Name	Relationship to Client
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

I can verify the above information because I am a(n):

[ ] Neighbor [ ] Employer [ ] School Official [ ] Childcare Provider
[ ] Friend [ ] Landlord [ ] Pastor [ ] Other:_____

How long have you known the family? [ ] Years [ ] Months [ ] Weeks

Print Name: _____ Date: _____

Signature: _____

Address: _____ Phone #: _____
_____
_____