University of Vermont Health

Statement of Residency

18 V.S.A. § 9481(12)

Patient's Name: _____

Patient's DOB: _____

Date: _____

In connection with my application for financial assistance under the University of Vermont Health financial assistance program, I hereby affirm the following:

1) I was living in Vermont at the time I received medical services subject to my financial assistance application; and

2) I lacked permanent stable housing at said time.

This document may be signed by a guardian or authorized caregiver instead of the patient. When this document is signed and provided to UVM Health in connection with a financial assistance application, the patient will not be required to furnish further proof of residency as a condition to receive financial assistance.

_____

Signature of Patient (or Guardian or Caregiver)

_____

Printed Name of Guardian or Caregiver (if applicable)