SAN BERNARDINO COUNTY DEPRTMENT OF PUBLIC HEALTH
RYAN WHITE/EARLY INTERVENTION SERVICES

Support Verification Affidavit

The following information is required for applicants who are being supported by another individual/agency or are homeless, and are unable to provide proof of income or residency.

Applicant's Name: _____
Print first name *Print middle initial* *Print last name*

Applicant's Current Residence: _____
Address

_____
City *State* *Zip*

The following statement is to be completed by the person who is providing support to the applicant.

The individual named above receives the following from me:
[_] Housing [_] Utilities [_] Food [_] Cash

I expect to continue to provide these items until: _____

My relationship to the person named above is: _____

I certify that the information in this section is true and correct.

Provider Name *(print):* _____

Provider Signature _____ Date _____

The following statement is **to be completed by the agency representative who is able to verify the client's living or support situation.**

The above named person receives the following services from this agency:
[_] Shelter [_] Social Services [_] Other: _____

I certify that the above named person is: [_] Homeless with no source of income,
[_] Homeless, but is a resident of San Bernardino/Riverside County, [_] Other _____

Agency Name *(print):* _____
Agency Representative *(print):* _____
Agency Address: _____

_____
City *State* *Zip*

Agency Telephone Number: _____