



**LITTLE COMPANY OF MARY**  
HOSPITAL AND HEALTH CARE CENTERS

*The Technology to Heal, the Mission to Care*

2800 West 95th Street, Evergreen Park, IL 60805

7 0 8 - 4 2 2 - 6 2 0 0

www.LCMH.org

## PROOF OF RESIDENCY FOR FINANCIAL ASSISTANCE

DATE \_\_\_\_\_

I, \_\_\_\_\_ do hereby swear that  
\_\_\_\_\_ resides in my home/apartment free  
of charge and provide his/her food and everyday necessities at this time.

I have been caring for him/her since \_\_\_\_\_ to date.

Patient Name \_\_\_\_\_

Patient Visit Number \_\_\_\_\_

\*If you live with someone and no rent is paid, please fill out this form and attach it to the Charity Care Application.

*NOTARY HERE*

\_\_\_\_\_  
PRINT NAME DATE

\_\_\_\_\_  
SIGN NAME DATE

\_\_\_\_\_  
WITNESS DATE

\_\_\_\_\_  
HOSPITAL REPRESENTATIVE DATE