# Financial Support Verification Form

**(USE ONLY IF APPLICANT IS UNEMPLOYED OR HOMEMAKER.)**

By signing this document, you are authorizing the individual named below to release financial assistance information to the Screening for Life **(SFL)** and Health Care Connection **(HCC)** Programs. The information below will **ONLY** be used to verify eligibility for the programs. Once you complete the client section of this document, submit this document to the individual named below and have them complete the Verifier Section. Please return the completed form to the SFL/HCC office either via email to **dhss_dph_healthaccessde@delaware.gov**, by FAX to **302-736-7940 or to 302-739-2545**, or by mail to **SFL/HCC Office, Division of Public Health, 540 S. DuPont Highway, STE. 11, Dover, DE 19901**

**SFL Applicant's Name:** _____ **SFL ID# (if assigned):** _____

## Applicant Section

**I**, _____**(Client's Name)**, hereby authorize _____ **(Supporter's Name)** to attest to providing me financial support to the **SFL** and **HCC** Programs for the purpose of verification of eligibility.

_____ _____/_____/ **2025**

**Signature of Client (Live)** **Date**

## Supporter Section

**Association to Client:** ☐ Partner (unmarried) ☐ Relative (not spouse) ☐ Friend

_____ _____

**Name of Supporter (Print)** **Contact Number**

_____ _____/_____/ **2025**

**Signature of Supporter (Live)** **Date**

**FOR SFL/HCC OFFICE USE ONLY**

**Verified By (SFL/HCC Employee Name and Title):** _____

**Date of Verification**: _____/_____/**2025**

**(SFL/HCC Receipt Date Stamp Above)**

**Any alterations made will void this document*