Denver County Residency Affidavit Denver Health and Hospital Authority

MY NAME IS: _								
		Provide Your Full Legal Name						
I RESIDE AT: _	Street Address							
	Street Addi		(55)	Арі.	Apt. #			
-	City	/	State	Zip	′ _	County		
MY PHONE NUM								
THE NAME OF	THE CICP APP	LICANT ("A	pplicant") is:					
(Check all that	apply)							
☐ Applicar	nt uses my add	ress as a mai	ling address,	but does not liv	e with 1	me.		
	nt uses my resid t does not live v	-	p his/her belo	ngings and/or o	ccasion	nally to showe	r, have a meal,	
☐ Applicar	nt occasionally	(twice per w	eek or less) st	ays at my resid	ence.			
		,		ed as a borrow			or included as a	
		•				• 00	or included as a sehold expenses.	
I HEREBY AGRI	EE to provide I	Denver Healt	th with docun	nentation of my	residei	ncy at the abo	ve address.	
I HEREBY AUT through indeper		er Health to	verify the ac	curacy of the in	nforma	tion provided	in this Affidavit	
THAT, IF ANY	OF THE INFO	RMATION I SE INFORMA	IS KNOWN T	O ME TO BE	FALSE	, I MAY BE	I UNDERSTAND COMMITTING A ECUTED TO THE	
Sign Your Full Legal Name Here]	Date		
			NOTA	DV				
STATE OF COLO	ORADO, COUN	ГҮ ОБ	NOTA					
					me a l	Notary Public	of said State duly	
commissioned and	sworn, personal	ly appeared:	, m the year <u>-</u>	, before	me, a	Total y 1 ubic	of said State, duly	
This person is pers		me (or prove					erson whose name is ath, executed same.	
In Witness Where written.	of, I have hereur	nto set my han	d and affixed n	ny official seal the	day and	d year in this ce	ertificate first above	
My Commission e	xpires:			Notary Pi	1.1:			
				Notary Pi	ıblic			