

**Part B Patient Care Program (Area 7)**  
**Proof of Residency in Florida**

Please complete the appropriate box for applicants who do not have any other form of proof of living in Florida.

*Not to be completed by the applicant.*

The applicant \_\_\_\_\_ currently resides at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This individual has been residing at the above address since: \_\_\_\_\_  
I do hereby certify the above information as true.

*Full Name:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Relation to Client:* \_\_\_\_\_

*Date:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

I certify that I am currently homeless and have no valid proof of living in Florida. I most often stay at the following location:

\_\_\_\_\_ A car parked near: \_\_\_\_\_

\_\_\_\_\_ A campsite or park located at: \_\_\_\_\_

\_\_\_\_\_ In an unoccupied building at: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

I have not had a permanent home since: \_\_\_\_\_

I receive mail at: \_\_\_\_\_

*Applicant Name:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_ *Phone:* \_\_\_\_\_