

**ATTESTATION FORM**

**Only use this form if you cannot provide proof of income documentation.**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

My estimated annual household income currently is \$\_\_\_\_\_.

(Please include dollar amount)

- \$\_\_\_\_\_ Social Security Disability Income (SSDI) (Beginning \_\_/\_\_)
- \$\_\_\_\_\_ Supplemental Security Income (SSI)
- \$\_\_\_\_\_ Aid from the Department of Public Welfare
- \$\_\_\_\_\_ Unemployment Benefits (From \_\_/\_\_ to \_\_/\_\_)
- \$\_\_\_\_\_ Workers Compensation Benefits (From \_\_/\_\_ to \_\_/\_\_)
- \$\_\_\_\_\_ Dividends, interest, or investment accounts
- \$\_\_\_\_\_ Employment (Myself and/or my spouse)
- \$\_\_\_\_\_ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household: \_\_\_\_\_

**Sponsor Contact Attestation:**

**Sponsor contact may sign below to attest to the patient's financial situation.**

To the best of my knowledge , I know the financial information provided on this application to be true.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Original Signature: \_\_\_\_\_

(Stamps not accepted)

Date: \_\_\_\_\_

**Patient Signature**

Patient Signature: \_\_\_\_\_