

ATTESTATION FORM

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

Name: _____

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: _____

Facility Contact Attestation:

Facility 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: _____

Date: _____

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