

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. This representation does not require my independent investigation of the information.

Print Name: _____

Title: _____

Original Signature: _____
(Stamps not accepted)

Date: _____

Patient Signature

Patient Signature: _____