TITLE 25 FINANCIAL AFFIDAVIT & CERTIFICATION

Patient Name:_____ **Account #:**_____

Admit Date: _____**Discharge Date:** _____

Do you have insurance? NO YES Name of Insurance _____

INCOME

Total wages, compensation, or any other source of income (alimony, child support, Social Security benefits, pension/retirement benefits, rents/royalties).

0.00- $9,999 $20,000- $29,999 $30,000- $39,999 $40,000- $49,999 $50,000 +

ASSETS

Do you have any of the following?

- Checking Account NO YES ***Value:***
- Savings Account NO YES ***Value:***
- Life Insurance NO YES ***Value:***
- Stocks NO YES ***Value:***
- Mutual Funds NO YES ***Value:***
- Real Estate NO YES ***Value:***

Estimated ***Total*** Value: _____

CURRENT LIABILITIES

Monthly mortgage or rent: _____ Monthly living expenses: _____

Medical expenses/other loans: _____ Number of Dependents: _____

_____ _____

Patient /Authorized Representative Signature **Date**

_____ _____

Witness **Date**

PROVIDER CERTIFICATION

I, the undersigned, certify that the above named patient did not have any public or private health insurance and that there are no other government benefit programs from which this provider can recover the costs of treatment from for the patient stay indicated above.

_____ _____

Provider CEO/CFO signature **Date**