

**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 assist ance 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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