Saint Michael's Medical Center

Patient Primary Attestation

Patient Name: _____ **Account Number:** _____

Date of Service: _____

Please Initial

_____ I and/or my spouse attest I/we have no income and have had no income since _____ to _____

_____ I and/or my spouse attest I/we have no assets as listed on the charity care application.

_____ I and/or my spouse attest I'm homeless and have been homeless since _____

_____ I and /or my spouse attest I/ we have no Medical Insurance to cover the outstanding amount for my hospital services.

_____ I attest that my name is _____ . I cannot provide proof of identification because: _____
(State Reason)

_____

_____ I and/or my spouse attest I/we have income. Our gross/cash income is _____ and we get paid on a _____ basis.
Frequency

_____ I and/or my spouse attest I/we have assets on the date of service above for the amount of _____ .

_____ I and/or my spouse attest I'm a resident of New Jersey and intend to keep New Jersey as my residence.

_____ I attest that I have not made and that I do not intend to make a claim against any third party in which I can seek payment, in whole or in part, for the medical services to which this application relates (including, without limitation, claims for no fault, worker's compensation, homeowners, underinsured or uninsured motorist insurance benefits and tort claims.) I understand and agree that, if any such claim is made, Saint Michael's Medical Center may retract its charity care and seek payment of all charges from me. I also agree to notify Saint Michael's Medical Center when a claim is filed.

X _____
Patient Signature

_____
Printed Name

_____
Date

Updated 5/24/16