



Patient ID: \_\_\_\_\_

**Written Attestation**

*Please complete the written attestation below as verification of how you meet your expenses.*

**Please Print:**

Patient Name: \_\_\_\_\_  
  First Name    Last Name

Patient DOB: \_\_\_\_\_  
  (mm/dd/yyyy)

I, \_\_\_\_\_ attest that my  
                        (First Name)    (Last Name)

current income is \$\_\_\_\_\_ on a monthly basis. I affirm this to be true and further state

I have no supporting documentation regarding this income for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Center/Area Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Director of Operations: \_\_\_\_\_ Date: \_\_\_\_\_