THIRD-PARTY SUPPORT AND VERIFICATION STATEMENT

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with statute 817.50, providing false information to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a misdemeanor in the second degree.

MR# _____

FINANCIAL SUPPORT

☐ I, _____, provide $ _____ per month to the patient referenced below.

THIRD-PARTY SUPPORT/THIRD-PARTY PAYMENTS

☐ I, _____ (supporter), provide room and board and other support for the patient referenced below. The person does not pay rent to me. My address is:

_____

Supporter Telephone# _____

☐ I, _____ (responsible party), certify I am the person responsible for making the payments in the amount of $_____ for the following expense(s). I have provided proof of payments.

Expense Name: _____ Amount: _____

Expense Name: _____ Amount: _____

Expense Name: _____ Amount: _____

Reference Loan Type or Loan #: _____ My Telephone # _____

My address is: _____

_____	_____	_____
Patient/Representative Signature	Patient/Representative Printed Name	Date
_____	_____	_____
Third-Party Supporter Signature	Third-Party Supporter Printed Name	Date
_____	_____	_____
JHS Representative Signature	JHS Representative Printed Name	Date Form Received

Notary stamp and signature are required if third-party person is not present at time of Financial Assessment.