ST. FRANCIS
MEDICAL CENTER
601 Hamilton Avenue
Trenton, NJ 08629
(609) 599-5000
Fax (609) 599-5692

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 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 use the following address for mailing purposes only: _____

_____

_____

____ I attest I have no Medical Insurance at the time of my admission to the Hospital.

____ 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 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 do not have any medical coverage through myself or any other party to cover the outstanding amount of my hospital services.

_____
Patient Signature

_____
Printed Name

_____
Date