Revised 06/2014

Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

MR# _____

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.

FINANCIAL SUPPORT

☐ I, _____, provided $ _____ last month to the patient referenced below.

THIRD-PARTY SUPPORT OF LIVING ARRANGEMENT

☐ I, _____ (supporter), provide room and board and other support for the patient referenced below. The person does not pay rent to me. I must provide proof of address for verification purpose. I am providing the patient with a current bill or other household document for him/her to show my current address.

THIRD-PARTY PAYMENTS to patient's credit accounts

☐ I, _____ (responsible party), certify I am the person responsible for making the payments in connection to the following expense(s) which are in the name of referenced patient. I must provide proof of payments. Please send documented proof with patient to his/her financial assessment.

Expense Name: _____ Amount: _____

Expense Name: _____ Amount: _____

Expense Name: _____ Amount: _____

Reference Loan Type or Loan #: _____

_____	_____	_____
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