Seneca
HEALTH SERVICES INC

ATTESTATION OF INCOME

Client Name/ID #: _____ **Date:** _____

☐ **I have been given the opportunity to apply for the Seneca Health Services sliding fee schedule and I DO NOT WISH to apply at this time.**

Patient Signature: _____ **Date:** _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your financial needs. This information will not be used to withhold or deny services to you.

Please include yourself, your spouse/partner and all dependents living in the home below:

NAME	Date of Birth	Relationship	Insurance or Medicaid
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

I attest that my household income for the time period in which I will receive financial assistance for services provided by Seneca Health Services is $_____ (annual/monthly).

I certify that the information provided is accurate and complete and to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for all or a portion of my care and that I will be asked to submit payment at the time of service.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____
(Seneca Staff)