The Safety Net Foundation
Providing assistance to those in need.

ATTESTATION FORM

OPTIONAL: Only use this form if you cannot provide proof of income documentation.

Name: _____ **Date of Birth:** _____

My estimated annual household income currently is $_____.
(Please include dollar amount)

- ☐ $_____ Social Security Disability Income (SSDI) (Beginning _____ / _____)
- ☐ $_____ Supplemental Security Income (SSI)
- ☐ $_____ Aid from the Department of Public Welfare
- ☐ $_____ Unemployment Benefits (From _____/_____ to _____/_____)
- ☐ $_____ Workers Compensation Benefits (From _____/_____ to _____/_____)
- ☐ $_____ Dividends, interest, or investment accounts
- ☐ $_____ Employment (Myself and/or my spouse)
- ☐ $_____ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household: _____

Facility Contact Attestation:

Facility contact may sign below to attest to the patient's financial situation.

To the best of my knowledge, I know the financial information provided on this application to be true.

Print Name: _____

Title:_____

Original Signature:_____
(Stamps not accepted) **Date:**

Patient Signature:_____
Date: