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 prove of address for verification purpose. I am providing the patient with a current expense bill or other household document for him/her to show you 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