FINANCIAL COUNSELING
UTMB Health, REVENUE CYCLE OPERATIONS, 301 UNIVERSITY BLVD
GALVESTON, TX 77555-1020 | PH#: 409.772-6464 | FAX# 409.772.7805

AFFIDAVIT CERTIFICATION

(Patient/Parent/Guardian must sign)

Patient Name:	MRN:

SUPPORTING STATEMENTS FOR APPLICATION FOR DISCOUNTED SERVICES

I,_____ , as guarantor for the above referenced account do hereby declare and certify the following statements:

INCOME:

My total gross family income is $_____. *(Check one)* → ☐ Weekly ☐ Monthly ☐ Yearly

ASSETS:

My total gross resources/assets are $_____. (*Homestead is Excluded*)

DEPENDENTS:

The total number of dependents in my family is _____. (*As claimed on current IRS Income Tax Return*)

INSURANCE/MEDICAL COVERAGE:

☐ **I am** ☐ **I am not** a participant in a private health insurers plan, group health plan, service benefit plan, health maintenance organization, a beneficiary of Medicare of Medicaid or other medical public assistance program.

If yes, please provide → Coverage name: _____ ID#:_____

RESIDENCY: I have lived in the state of Texas from _____ / _____ / _____ until _____ / _____ / _____

(Check one) → I certify that I ☐ **currently** or ☐ **intend to** reside at the below address as of: _____ / _____ / _____

_____

PHYSICAL/HOME ADDRESS CITY STATE ZIPCODE

_____

MAILING ADDRESS IF DIFFERENT FROM PHYSICAL/HOME ADDRESS

CONTACT PHONE#: (_____) _____ – _____

AFFIDAVIT:

I do hereby declare and certify that the above information provided is true and correct to the best of my knowledge. I further understand that this affidavit is only a temporary measure and that I must furnish documented and verifiable proof of the above statements. **The following information must be submitted within fourteen (14) days of today.**

_____

_____

_____

I authorize UTMB Hospitals to verify my statements of family size, income, insurability and other submitted information. I authorize UTMB to investigate my employment history and my credit history. I understand that if information I have submitted is found to be invalid, further services may be denied unless paid in full, in advance. I also recognize that making fraudulent statements in application for services makes me liable for legal prosecution and discontinuance of further UTMB care.

SIGNATURE:_____ **DATE:**_____

Patient / Parent / Guarantor *(circle one)*

WITNESS SIGNATURE:_____ **DATE:**_____

If you have questions, please call Financial Counseling at (409) 772-6464.