SALEM MEDICAL CENTER

PATIENT / RESPONSIBLE PARTY CERTIFICATIONS

Patient last name: ____ Patient first name: __________________________________

Responsible party name: ____Relationship: ___________________________

Account #: ____ Date of service: _____________________________

Please place initials to the left of all applicable attestations.

____ I attest that I am single.

____ I attest that I am married. Spouse's name ___________________________________ Birthdate ____________

____ I attest that I am legally divorced.

____ I attest that I am a widow / widower.

____ I attest that I have been separated from my spouse since _______________ and that we have no financial ties.

____ I attest that I have ______ dependent children who reside with me.

Name	Birthdate
____	__________________
____	__________________
____	__________________

____ I attest that I am legally married to my child / children's other parent.

____ I attest that I am legally divorced from my child / children's other parent.

____ I attest that I was never legally married to my child / children's other parent.

____ I attest that I am separated from my child / children's other parent.

____ I attest that I **do not** receive child support.

____ I attest that I had **no income** for _______ months immediately prior to my date of service.

____ I attest that I had **no assets** at the time of my date of service or for _______ months prior.

____ I attest that I have **no insurance** to cover hospital services rendered on ________________.

____ I attest that I have been a New Jersey resident since ________ and intend to remain in this State for the foreseeable future.

____ I attest that I am **not** a New Jersey resident. I was admitted to the hospital as the direct result of an emergency.

____ I attest that I was screened and advised of my eligibility for New Jersey Medicaid, but have categorically refused to apply.

____ I attest that the information here provided is true and correct to the best of my knowledge.

Signature: ____ Date: ________________________