West Jefferson Medical Center
Our Family Caring For Your Family

THIRD-PARTY SUPPORT AND VERIFICATION STATEMENT

Patient Name: _____

Date of Birth: _____

MRN #: _____

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 Louisiana State Statute 1924, providing false information can be considered "Health Care Fraud" in an attempt to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a felony.

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 understand that I must provide proof of payments. Please send documented proof with patient to his/her financial assessment. (Provide additional information on separate sheet.)

Expense Name: _____ Amount: _____

Expense Name: _____ Amount: _____

Expense Name: _____ Amount: _____

Reference Loan Type or Loan #: _____

*Signature is required if third-party person not present at time of Financial Assessment

_____	_____	_____
Patient/Representative Signature	Patient/Representative Printed Name	Date
_____	_____	_____
*Third-Party Supporter Signature	Third-Party Supporter Printed Name	Date
_____	_____	_____
West Jefferson Medical Center Representative Signature	West Jefferson Medical Center Representative Printed Name	Date Form Received