MOREHEAD
MEMORIAL·HOSPITAL

FINANCIAL ATTESTATION

Unit#_____

*Information provided through the Financial Disclosure form is valid for 1 year from the date of application **or** until changes in your financial situation occur that may be relevant in determining financial assistance eligibility.*

_____ _____
Patient Name SSN

I hereby certify that there have been no significant changes to my financial situation since my application for financial assistance was completed on_____.

I confirm that all information on that application is correct and complete to the best of my knowledge, information, and belief. I understand and agree that if Morehead Memorial Hospital learns that I have made false statements or misrepresented any information on that application or this attestation, it may seek legal action against me to recover the amount of financial assistance provided, as well as related costs and attorneys' fees.

_____ _____
Signature Date

_____ _____
Person signing (if different from applicant) Relationship to patient

_____ _____
State # of Persons in house

_____ _____
Assets - Total $ % of Discount

_____	_____	$_____	_____
Acct. #	D.O.S.	Amount	INS/SP
_____	_____	$_____	_____
Acct. #	D.O.S.	Amount	INS/SP
_____	_____	$_____	_____
Acct. #	D.O.S.	Amount	INS/SP

Please return signed form to:
Morehead Memorial Hospital
Patient Accounting
117 E. Kings Hwy.
Eden, NC 27288-5201