TALLAHASSEE MEMORIAL HEALTHCARE

# Homeless Affidavit

Date of Service: _____ Account #: _____

Patient Name: _____

To Whom It May Concern:

_____ was a patient of Tallahassee Memorial Hospital and has stated that he/she is homeless and has no income.

I understand that providing false information to defraud a hospital for purpose of goods or services is a misdemeanor in the second degree and punishable by Florida statue 817.50. I certify that the above information is true to the best of my knowledge.

_____ _____

Patient's Signature Date

Being a representative of Tallahassee Memorial Hospital, I am advising any and all interested parties, by this document, of the same.

Other than the statement of the patient, I cannot provide further information as to his/her status.

_____ _____

Witness's Signature Date

**1607-1 Saint James Ct.**
**Tallahassee, FL 32308**
**Office: (850) 431-6200**
**Fax: (850) 431-6951**
**Toll Free: (800) 492-4892 ext. 16200**

*January 2024*