TALLAHASSEE MEMORIAL HEALTHCARE

Place Patient Label Here

Statement of Financial Assistance
Statement of Residency

I, _____ certify that I am providing the following assistance for (patient name) _____

Relationship to Patient: _____

Shelter: Yes _____ No _____

The address of the shelter being provided is: _____

Cash: Yes _____ (amount per month) $_____

Food: _____

IF PATIENT HAS THEIR OWN SHELTER, BUT YOU ARE PROVIDING FINANCIAL ASSISTANCE ONLY, PLEASE COMPLETE THE FOLLOWING:

Paying bills directly for:

Electric:	Yes ___ No ___	**Phone:**	Yes ___ No ___
Mortgage or Rent:	Yes ___ No ___	**Food:**	Yes ___ No ___

******THIS FORM MUST BE NOTARIZED******

Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____day of _____, 20___, by

_____.
Name of person acknowledging

_____
Signature of Notary Public

(NOTARY SEAL)

_____
Name of Notary Typed, Printed, or Stamped

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Patient Account Coordinator II
Patient Financial Services

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

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