HOPE CLINIC
delivering hope & health

Patient ID: _____

Written Attestation

Please complete the written attestation below as verification of how you meet your expenses.

Please Print:

Patient Name: _____

Patient DOB: _____/_____/_____

I, _____ attest that my current
(First Name) (Last Name)

income is $ _____ on a monthly basis. I affirm this to be true and further

state that I have no supporting documentation regarding this income for the following reason(s):

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Enroller: _____ Date: _____

Operations Manager
Or Patient Care Coordinator: _____ Date: _____