

MEDICALLY INDIGENT (MI) APPLICATION  
INCOME & INSURANCE ATTESTATION

Account # \_\_\_\_\_ MR # \_\_\_\_\_ Admit/Service Date \_\_\_\_\_

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

The income reported on my Medically Indigent Application reflects all sources (Employment) of income for the family unit.

Yes  
 No

Is the patient, listed above covered by any health insurance plan?

Yes  
 No

Any deduction shown as an insurance premium will be validated that the above patient is not covered by the health insurance plan.

Comments:

---

---

It is the responsibility of the patient/applicant to report to this department when there are any changes in the family unit income, employment and/or insurance.  
Any false statements could lead to the denial or revocation of this application and the patient shall be held responsible for all charges incurred.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hospital Representative Taking MI Application

\_\_\_\_\_  
Date