Certification of No Income

I, the undersigned patient, hereby certify that I received no income from any source during the time period of ____/____/____ through ____/____/____. I understand that
(mm dd yy) (mm dd yy)

this certification shall be used to determine what amounts I may owe on my medical bills from Cabell Huntington Hospital. I further understand that, if Cabell Huntington Hospital later determines that I did receive income during the time period listed above, I will be held responsible for paying those medical bills.

For the following dates of service or account numbers:

____

____

____

Did you file federal income tax for the previous tax year? Please, circle and initial one of the following choices:

Yes: _______

No: _______

____ ________________
Patient Signature Date

____ ________________
Patient Name (Please Print) Date of Birth

____ ________________
Witness (someone other than immediate family) Date

10/14/2022