STATE OF TEXAS §
§
COUNTY OF MONTGOMERY §

AFFIDAVIT REGARDING MARITAL STATUS AND FINANCIAL SUPPORT

Before me the undersigned authority on this day did appear _____, who upon his/her oath deposed and stated;

1. "My name is _____, I am over twenty-one years of age and I am competent to make this affidavit, I have personal knowledge of the following facts and they are true and correct

2. I am a legal resident of Montgomery County, and currently reside at _____

3. I am / was married to _____, whose social security number is _____ We were married on _____

4. I am currently separated / divorced from my spouse. We ceased living together as husband and wife on, or about, _____.My spouse does not reside in the same residence that I do. The present whereabouts of my spouse are unknown to me.

5. I currently receive no financial support of any sort from my spouse, nor have I received any financial support from my spouse in the past _____ months. I currently pay all of my expenses solely from my income sources, and do not rely upon income produced by my spouse or my spouse's property, or family members of my spouse to pay any of my expenses.

6. I am applying for Health Care Assistance from the Montgomery County Hospital District and understand that representatives of the District are relying upon the facts stated herein to determine my eligibility for health care assistance, including the information regarding my financial resources.

7. I warrant and attest that the information I have furnished to the Montgomery County Hospital District in connection with my request for Health Care Assistance is true and correct, and is complete.

8. I hereby assign to the Montgomery County Hospital District my right to recover from the community property, or other available assets of my marriage to the extent of the amounts expended by the Montgomery County Hospital District in providing health care assistance to me. I further consent and agree to not interfere with any collection activities instituted by Montgomery County Hospital District in its efforts to recover health care expenses paid on my behalf from third parties and/or other sources.

9. I HEREBY AFFIRM UNDER PENALTIES OF PERJURY THAT THE ABOVE FACTS ARE TRUE AND CORRECT. I FURTHER UNDERSTAND AND AGREE THAT THE MONTGOMERY COUNTY HOSPITAL DISTRICT MAY IMMEDIATELY CANCEL HEALTH CARE ASSISTANCE TO ME SHOULD IT BE J>ETERMINED THAT ANY INFORl"\IATION I HAVE PROVIDED TO THEM IS FALSE OR MISLEADING. I UNDERSTAND THAT THE MONTGOMERY COUNTY HOSPITAL J>ISTRICT MAY REFER ANY FALSE STATEMENTS CONTAINED HEREIN FOR CRIMINAL PROSECUTION.

Further Affiant sayeth not."

APPLICANT:

_____ _____

Date Signature

_____

Printed Name

SWORN AND SUBSCRIBED before me on this _____ day of _____, 20___.

_____

Notary Public In and for the
State of Texas

My Commission Expires:_____