Financial Assistance Program Application

Our hospital is committed to care for all patients regardless of their ability to pay. Patients who are unable to pay for services may be eligible for Financial Assistance. Please complete and return the following form with requested documents to the Facility Registration Department or Financial Counselor to be evaluated for Financial Assistance.

Patient Account(s) #:_____ Date of Application:_____

PATIENT INFORMATION

Name:_____
Address:_____
City:_____
State/Zip:_____
SSN:_____
Employer:_____
Address:_____
City:_____
State/Zip:_____
Work Phone:_____
Length of Employment:_____
Supervisor:_____

PARENT/GUARANTOR/SPOUSE

Name:_____
Address:_____
City:_____
State/Zip:_____
SSN:_____
Employer:_____
Address:_____
City:_____
State/Zip:_____
Work Phone:_____
Length of Employment:_____
Supervisor:_____

RESOURCES

Checking: Yes ____ No____ Amount: $_____
Savings (including flexible spending and health savings accounts):
Yes ____ No ____ Amount: $_____
Bonds: $_____
Cash on Hand: $_____
Certificate of Deposit(s): $_____
IRA Account(s): $_____
Roth Account(s): $_____
Stock/Other Financial Investment Account(s) (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)) : $_____
Trust Fund Account(s): $_____
Vehicle 1: Yr:_____ Make:_____ Model:_____
Vehicle 2: Yr:_____ Make:_____ Model:_____
Vehicle 3: Yr:_____ Make:_____ Model:_____
Vehicle 4: Yr:_____ Make:_____ Model:_____
Vehicle 5: Yr: _____ Make:_____ Model:_____
(This includes recreational vehicles such as: boats, campers, etc.)

INCOME

Patient/Guarantor Wages
(monthly): $_____

Spouse/Second Parent Wages
(monthly): $_____

Other Income

Child Support: $_____
VA Benefits: $_____
Workers Comp: $_____
SSI: $_____

Other Income

Child Support: $_____
VA Benefits: $_____
Workers Comp: $_____
SSI: $_____

LIVING ARRANGEMENTS

Primary Residence:
Rent: $_____ Own: $_____ Other(explain): $_____
Landlord/Mortgage Holder: _____
Phone Number: _____ Monthly Payment: $_____
Second Home/Other Property: Rent: _____ Own: _____ (check one)
Value: $_____ Loan Amount: $_____ Payment: $_____
House Rent/Mortgage Payment: $_____
Other Property Payment: $_____
Utilities: $_____ Gas: $_____
Auto: $_____ Loans: $_____
Medical Bills: $_____ Food: $_____
Child Support: $_____ Other: $_____

REQUESTED AVAILABLE DOCUMENTS

Proof of Income:

___ Last 4 paystubs
___ Letter from employer
___ Social Security benefits (if applicable)
___ Last 3 months bank statements
___ Previous years Federal Tax Return

Proof of Expenses:

___ Copy of mortgage payment OR
___ Copy of rental agreement
___ Other documents requested
___ Copies of monthly bills

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in the denial of any financial assistance by the hospital.

Signature of Applicant: _____

Hospital Representative completing the application: _____