Financial assistance application form

UAB ST. VINCENT'S

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date_____ Account number _____

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____
Applicant spouse income _____
Social security benefits _____
Pension/retirement income _____
Disability income _____
Unemployment compensation _____
Worker's compensation _____
Interest/dividend income _____

Child support received _____
Alimony received _____
Rental property income _____
Food stamps _____
Trust fund distribution received _____
Other income _____
Other income _____
Total gross monthly income $ _____

Monthly living expenses

Mortgage/rent _____
Utilities _____
Phone (landline) _____
Cell phone _____
Groceries/food _____
Cable/internet/satellite tv _____
Car payment _____
Child care _____

Child support/alimony _____
Credit cards _____
Doctor/hospital bills _____
Car/auto insurance _____
Home/property insurance _____
Medical/health insurance _____
Life insurance _____
Other monthly expense _____
Total monthly expenses $ _____

Assets

Cash/savings/checking accounts _____
Stocks/bonds/investments/CD(s) _____
Other real estate/secondary residence _____
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles _____
Other assets _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Signature of Applicant _____

Date _____

Comments _____