Financial Assistance Application Form

Patient information
(Please print – 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): _____

Date of birth: _____ 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 the patient is the same as the responsible party, leave this section blank.)
Name (first and last): _____

Date of birth: _____ 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 the patient is the same as the responsible party, fill in spouse information for the patient.)
Name (first and last): _____

Date of birth: _____ 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 the responsible party
(If the patient is the same as the responsible party, fill in spouse information for the patient.)
Name: _____ DOB: _____ Relationship to responsible party: _____

Name: _____ DOB: _____ Relationship to responsible party: _____

Name: _____ DOB: _____ Relationship to responsible party: _____

Name: _____ DOB: _____ Relationship to responsible party: _____

Number of adults and children living in household: _____

Monthly income

(Fill in the dollar amounts for each item listed below. Provide the 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.

Applicant signature: _____ Date: _____

Comments:_____

_____

_____