

## APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION								
Patient Name			Age	Telephone No.		Patient No.		
Home Address					Rent <input type="checkbox"/>	Live with parents? No <input type="checkbox"/> Yes <input type="checkbox"/>		
					Own <input type="checkbox"/>			
SSN	Marital Status		Discharge diagnosis			If pregnant, due date?		
Name & Address of employer				Employer Telephone No.		How long employed?		
Position/Title				Supervisor's Name				
If unemployed, last date & place of employment				Position/Title				
RESPONSIBLE PARTY INFORMATION								
Name		Relationship to patient		Age	Telephone No.			
Street address, if different from patient								
SSN	Marital Status		Family Size	Names & Ages				
Name & Address of Employer				How long employed?	Employer Telephone No.			
Position/Title				Supervisor's Name				
If unemployed, last date & place of employment				Position/Title				
Name of Nearest Relative					Relationship			
Address					Telephone No.			
SPOUSE INFORMATION								
Name		Age	SSN		Name of Employer			
Employer Address			How long employed?	Employer Telephone No.				
Position/Title			Supervisor's Name					
If unemployed, last date & place of employment					Position/Title			
MONTHLY INCOME				ASSETS				
ITEM	<input type="checkbox"/> Patient <input type="checkbox"/> Father	<input type="checkbox"/> Spouse <input type="checkbox"/> Mother	<input type="checkbox"/> Patient <input type="checkbox"/> Father	<input type="checkbox"/> Spouse <input type="checkbox"/> Mother	<input type="checkbox"/> Patient <input type="checkbox"/> Father	<input type="checkbox"/> Spouse <input type="checkbox"/> Mother	Checking Account(s) – bank & account number	Balance
Base Income								
Overtime							Savings Account(s) – bank & account number	Balance
Social Security								
Interest/Dividends							Other (bank & account number, money market, CD, IRA)	Balance
Rental Income								
Alimony/Child Support							Life Insurance (company & policy number)	Value
Unemployment								
State Assistance							Stocks, Bonds & Mutual Funds (company)	Value
Food Stamps								
Pension							Automobiles/Trucks (make, model & year)	Value
Disability								
Worker's Compensation								
Other							Other Assets (personal, livestock, machinery, motorcycles, RVs)	Value
							Real Estate (list and describe)	Present Value
<b>TOTAL</b>							<b>TOTAL ASSETS</b>	

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW. PLEASE PROVIDE THE FOLLOWING ITEMS:

1. MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX
2. BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS; LAST THREE MONTHS)
3. VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC)

MONTHLY EXPENSES		OTHER EXPENSES	MONTHLY PAYMENT	BALANCE	PAYMENT CURRENT?
<b>ITEM</b>	<b>MONTHLY PAYMENT</b>	Charge Accounts			<input type="checkbox"/> No <input type="checkbox"/> Yes
Rent					<input type="checkbox"/> No <input type="checkbox"/> Yes
Mortgage					<input type="checkbox"/> No <input type="checkbox"/> Yes
Electricity					<input type="checkbox"/> No <input type="checkbox"/> Yes
Gas/Propane					<input type="checkbox"/> No <input type="checkbox"/> Yes
Water					<input type="checkbox"/> No <input type="checkbox"/> Yes
Refuse		Personal Loan (name & purpose)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Telephone					<input type="checkbox"/> No <input type="checkbox"/> Yes
Cable TV		Automobile Loan (name)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Food					<input type="checkbox"/> No <input type="checkbox"/> Yes
Clothing		Real Estate Loan (name)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicine					<input type="checkbox"/> No <input type="checkbox"/> Yes
Baby Sitter		Cellular Phones/Pager			<input type="checkbox"/> No <input type="checkbox"/> Yes
Transportation					<input type="checkbox"/> No <input type="checkbox"/> Yes
Alimony/Child Support		Miscellaneous (name & purpose)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Auto Insurance					<input type="checkbox"/> No <input type="checkbox"/> Yes
Home Insurance					<input type="checkbox"/> No <input type="checkbox"/> Yes
Life Insurance		<b>TOTALS</b>	<b>TOTAL MONTHLY PAYMENTS</b>	<b>TOTAL BALANCE</b>	
Health Insurance					
Personal Property Tax					
Real Estate Tax					
Sub-total		<b>SUMMARY</b>			
		<b>Total Monthly Income</b>		\$ _____	
		<b>Total Monthly Expenses</b>		\$ _____	
		<b>Discretionary Income</b>		\$ _____	
		<b>Monthly Payment Arrangements</b>		\$ _____	
<b>OTHER EXPENSES</b>					
Will the patient be unable to work or go to school due to physical impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, what is the disabling condition or diagnosis? _____					
How long will the patient be disabled? _____ (Please attach a statement from the doctor.)					
<b>COMMENTS</b>					
<b>PATIENT AGREEMENT</b>					
The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus.					
Patient Signature _____					
Responsible Party or Spouse Signature _____					
Facility Representative Department _____					
Date _____					