Financial Assistance Application

General Information

Patient Account # _____ **Patient Name** _____

Patient SS # _____ **Home Telephone** _____

Date of Birth _____ **Email Address** _____

Address _____

City _____ **State** _____ **ZIP** _____

Health Insurance Status/Third Party Payor Information

Private Insurance _____ **Medicare** _____ **Chip** _____

Group Insurance _____ **Medicaid** _____ **Vocational Rehabilitation** _____

Other _____

Household Members

Name of Member	Relation to Patient	Age

Gross Income (before taxes)

	Weekly	Bi-Weekly	Monthly
Responsible Party			
Spouse			
Mother			
Father			
Other			

I attest that the information provided in this application is correct. I understand that misrepresentation of any information provided will result in denial of charity care allocation. I acknowledge that if any information I have given is false or misleading and results in approval of charity care allocation, the hospital may take whatever action it deems appropriate which may include revocation of charity allocation approval and reinstituting

Signature _____ **Date** _____

Witness _____ **Date** _____