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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Income Information

ONE OF THE FOLLOWING THREE DOCUMENTS MUST BE ATTACHED OR APPLICATION WILL BE DENIED AS INCOMPLETE:

THREE (3) MONTHS WORTH OF CHECK STUBS (OR AS MANY AS YOU HAVE) FOR ALL WORKING MEMBERS OF THE HOUSEHOLD:

LAST YEARS W-2 FORM FOR ALL WORKING MEMEBERS OF THE HOUSEHOLD OR YOUR LAST YEARS TAX RETURN.

IF YOU ARE UNEMPLOYED & NOT RECEIVING BENEFITS YOU WILL NEED A LETTER OF SUPORT FROM THE PERSON PROVIDING THE SUPPORT.

IF YOU ARE A STUDENT ON YOUR OWN, A COPY OF YOUR AWARD LETTER FOR THE CURRENT YEAR.

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** _____