Financial Assistance Application

1. GENERAL INFORMATION:

Patient Account Number ______________________ Patient Name ______________________

Patient Social Security Number ______________________ Telephone Number ______________________

Date of Birth ______________________ Email Address ______________________

Address ____

City ______________________ State __________ Zip __________

2. HEALTH INFORMATION STATUS/THIRD PARTY PAYOR INFORMATION:

Private Insurance __________ Medicare __________ CHIP __________

Group Insurance __________ Medicaid __________ Vocational Rehab __________

Other ______________________

3. HOUSEHOLD MEMBERS:

Name of Member	Relationship to Patient	Age
____________	____________	______
____________	____________	______
____________	____________	______
____________	____________	______

4. INCOME INFORMATION:

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

- Three (3) months of check stubs (or as many as you have) for all working members of the household
- Last year's W-2 form for all working members of the household or your last year's tax return
- If you are unemployed and not receiving benefits you will need a letter of support from the person providing support from the person providing the support. (Included with this application)
- 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 reinstitution.

Signature ______________________ Date ______________________

Witness ______________________ Date ______________________

FINANCIAL ASSISTANCE
LETTER OF SUPPORT

Patient Information

Date ______________________________ Date of Service______________________

Account Number ______________________ Phone Number ______________________

Patients Name ______________________

Address ______________________

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REMAINDER OF FORM TO BE COMPLETED BY PERSON PAYING LIVING EXPENSES OR PROVIDING LIVING ASSISTANCT TO PATIENT.

Name ______________________ Relationship ______________________

Address ______________________ Phone Number ______________________

____

I, ______________________, provide shelter and financial assistance (food, utilities only) to: ______________________.

I have provided assistance from ______________ to ______________.
(date) (date)

____
Signature of person providing assistance

____
Date