APPLICATION FOR FINANCIAL ASSISTANCE

PART 1 - HOUSEHOLD INFORMATION - To Be Completed By Applicant

Name: First, Middle, Last	Date of Birth			Relationship to Applicant	Health Insurance or 3rd Party Coverage
				PATIENT	Yes ___ No ___
					Yes ___ No ___
					Yes ___ No ___
					Yes ___ No ___
					Yes ___ No ___
					Yes ___ No ___
					Yes ___ No ___

Address: ____

Mailing Address: ____

Phone Number: _________________________________ Living Situation: Rent ___ Own ___ Other ___ U.S. Citizen: Yes ___ No ___

Alien Registration No: ___________________

PART 2- FINANCIAL INFORMATION - To Be Completed By Applicant

EXAMPLES	INCOME			EXAMPLES	ASSETS	
	TYPE	WHO	GROSS AMOUNT (*LAST 12 MONTHS*)		TYPE	VALUE
Wages, Self Employment, Social Security, Child Support Contributions, Unemployment Compensation, Railroad Retirement, SSI, AFDC				Cash, Checking Account, Car/Truck, Motorcycle, Burial Insurance, Trust Funds, Life Insurance, Burial Plot, Real Estate, Business Equipment, Boat, Stocks/Bonds, Savings		

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will complete an application for any assistance (Medicare, Medicaid, Insurance, etc.) that may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign pay to the hospital for the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request: _______________________________ Applicant Signature: ____