Spouse Employment/Income Information:

Company ______________________ Title ______________________

Address ______________________ Salary $____________ Per __________ (Weekly/Monthly/Yearly)

______________________ # of Years ____________

Insurance Information:

Has the patient applied for Medicaid? __________ (Y/N) Was the patient approved? __________ (Y/N)

Did the patient have health insurance at the time of this hospital service? _________ (Y/N)

If Yes, please fill out the following:

Name of Insurance ______________________ Effective Date _____/_____/_______

Name of Policyholder ______________________ Policy Number ________________

(Application Continued On Back)

FINANCIAL ASSISTANCE APPLICATION - Continued

Other Monthly Income Information:

VA Benefits $______________ Retirement $______________ SSI $______________

Child Support $______________ Unemployment $______________ Other $______________

Assets:

Checking Account Balance $__________________ Savings Account Balance $__________________

Other Asset(s) Balance(s) $__________________ (CDs, Stocks, Bonds, Money Market Accounts, etc.)

Total ALL Asset Expenses $____________________

Monthly Expenses:

Rent/Mortgage	$______________________	Utilities	$______________________
Food	$______________________	Charge Cards	$______________________
Auto Payment(s)	$______________________	Auto Insurance(s)	$______________________
Medical Expense(s)	$______________________	Pharmacy	$______________________
Child Care	$______________________	Other	$______________________

Total ALL Monthly Expenses $____________________________

Real Estate:

Estimated Value of Home $___________________________ Mortgage Balance(s) $___________________________

SUPPORT STATEMENT

(To be completed by the person providing support.)

I have been identified by the applicant as providing financial support. Below is a list of services I provide the applicant.

____

____

____

____

____

I hereby certify and verify that all of the above information given is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the patient's medical charges.

Signature____ Date ___________________________

I hereby certify, under penalty of perjury, that the answers I have given are true and correct to the best of my knowledge.

I agree to tell the provider of services within 10 days if there are any changes in my (or the person's on whose behalf I am acting) income, property, expenses, number of persons in the household, or change of address.

I understand that I may be asked to prove my statements, and that my eligibility statements will be subject to verification by contact with my employer, bank, credit providers and property searches.

I understand that the hospital is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such incident.

I understand that if I do not qualify for Financial Assistance, I may appeal that decision in writing with additional documentation. If I am still denied for Financial Assistance, I may be responsible for payment of the outstanding invoice(s).

Signature____ Date ___________________________