

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION

Name:

Date of birth:

SSN:

Phone:

Current address:

City:

State:

ZIP Code:

Cell Phone:

E-mail Address:

EMPLOYMENT INFORMATION

Please indicate if you are Employed/Retired/Disabled:

Current employer (I/A):

Employer address:

How long?

City:

State:

ZIP Code:

Position:

Annual income:

HOUSEHOLD CO-APPLICANT INFORMATION

Name:

Date of birth:

SSN:

Phone:

Current address:

City:

State:

ZIP Code:

EMPLOYMENT INFORMATION

Please indicate if the co-applicant is Employed/Retired/Disabled:

Current employer (I/A):

Employer address:

How long?

City:

State:

ZIP Code:

Position:

Annual income:

ADDITIONAL HOUSEHOLD MEMBERS AND INCOME, IF ANY

Name

Relationship to Applicant and Age

Annual Income

OTHER ASSETS OR SOURCES OF INCOME - **(SEE "PROOF OF ASSETS" ON CHECKLIST)**

Description

Amount per month or value

FINANCIAL ASSISTANCE APPLICATION

ACCOUNTS RELATED TO APPLICATION REQUEST **** (FOR OFFICE USE ONLY) ****

Patient Name:	Account no.	Date of Service:	Amount:

I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated health services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant	Date
Signature of co-applicant, I/A	Date

ELIGIBILITY DETERMINATION (FOR OFFICE USE ONLY)

Date Received: _____ Verification Completed: Yes ____ No ____

The applicant was approved for a reduction of _____ % of allowable charges. Date approved: _____

The applicant was denied for the following reason(s)

Date of Denial _____

Date Applicant Notified of Determination _____

Individual Completing Review: _____