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

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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: ____