# Financial Assistance Form

## Charity Care/Financial Assistance Program Application

Exhibit C

Patient Account Number _____

Date of Application _____

**PATIENT INFORMATION**

Name _____

Address _____

City _____

State/Zip _____

Phone # _____

Employer _____

Address _____

City _____

State/Zip _____

Work Phone _____

Length of Employment _____

Supervisor _____

**GUARDIAN INFORMATION**

Name _____

Address _____

City _____

State/Zip _____

Phone # _____

Employer _____

Address _____

City _____

State/Zip _____

Work Phone _____

Length of Employment _____

Supervisor _____

RESOURCES

Checking: yes___ no___

Savings: yes___ no___

Cash on hand: $_____

Number in Household: _____

Vehicle 1: Yr_____ Make_____ Model_____

Vehicle 2: Yr_____ Make_____ Model_____

Vehicle 3: Yr_____ Make_____ Model_____

Application Deadline: _____

Received application: _____

Initials: _____

Exhibit C (continued)
Charity Care/Financial Assistance Program Application



INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

==========

The below signatures is indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Charity Write-Off Amount Approved $_____

BOM_____ CEO_____

CFO_____