LANGLEY PORTER PSYCHIATRIC HOSPITAL & CLINICS
Financial Assistance Application

1. PATIENT INFORMATION				
Last Name	**First Name**	**Middle**	**Account Number**	**Medical Record Number**

2. APPLICANT INFORMATION	**RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____	**Marital Status** ☐ Married ☐ Single ☐ Separated **IF MARRIED, SECTION 3 MUST BE COMPLETED**	
Last Name	**First Name**	**Middle**	**U.S. Citizen (see #6)** ☐ Yes ☐ No
Date of Birth	**No. of Dependents** (other than self & spouse)	**Ages of Dependents**	**Home Phone**

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**

Current Employer	**Street Address, City, State**	**Position**

3. CO-APPLICANT INFORMATION			**RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____	
Last Name	**First Name**	**Middle**	**Relationship to Applicant**	**U.S. Citizen (see #6)** ☐ Yes ☐ No
Date of Birth	**No. of Dependents** (do not include those claimed by applicant)	**Ages of Dependents**	**Home Phone**	

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**

Current Employer	**Street Address, City, State**

4. INCOME INFORMATION **(Supporting documentation required)**				
	Monthly Income Sources	**Applicant**	**Co-Applicant**	**Total**
	Employment Income	$	$	$
	Social Security	$	$	$
	Alimony/Child Support	$	$	$
	Other: (*Unemployment, Disability, Pension, etc*.)	$	$	$
		Total Combined Monthly Income		$

PLEASE COMPLETE SECOND PAGE OF APPLICATION

Patient Last Name(s): _____ **LPPH&C**
Applicant(s) Last Name(s): _____ **Financial Assistance Application**

4. ESSENTIAL LIVING EXPENSE INFORMATION (Supporting documentation required)				
	Monthly Essential Living Expenses	**Applicant**	**Co-Applicant**	**Total**
	Rent or House Payments	$	$	$
	Food and Household Supplies	$	$	$
	Utilities and Telephone	$	$	$
	Clothing	$	$	$
	Medical and Dental Payments	$	$	$
	Insurance	$	$	$
	School or Child Care	$	$	$
	Child or Spousal Support	$	$	$
	Transportation and Auto Expenses	$	$	$
	Laundry and Cleaning	$	$	$
	Other Essential Expenses	$	$	$
			Total Combined Living Expenses	$

6. SUPPORTING DOCUMENTATION (REQUIRED)

From both applicant & co-applicant

- ✓ Copy of most recent (2 months) pay stubs for both applicant & co-applicant.
- ✓ Copy of receipts for essential living expenses (2 months of receipts per category)
- ✓ Copy of current year or previous year's W-2 or 1099 earnings statements for both applicant & co-applicant.
- ✓ Copy of current year's or previous year's Income Tax Return
- ✓ Copy of Social Security Allotment letter and/or other proof of income **(section 4)**
- ✓ Copy of valid Legal Permanent Resident card if non-US citizen is required.

Note: Application may be denied if supporting documentation (as listed above) is missing

8. SIGNATURE AND DATE (REQUIRED OF APPLICANT AND CO-APPLICANT)

I certify that all information is true and complete, and hereby authorize Langley Porter Psychiatric Hospital and Clinics to report and/or verify any of the above information as deemed necessary. I understand that incomplete applications may be denied. I understand that I may be required to complete a new application for future services. I agree to notify Langley Porter Psychiatry Hospital and Clinics of any changes to my financial circumstances that may affect my eligibility for financial assistance.

Applicant **Date** **Co-Applicant** **Date**

_____ _____