Patients' Hospital of Redding

Financial Assistance Application

PATIENT NAME_____ **SPOUSE/DOMESTIC PARTNER**_____
ADDRESS_____ **PHONE**_____
ACCOUNT#_____ **SS#**_____

FAMILY STATUS: *List all dependents that you support*

Name	**Age**	**Relationship**

EMPLOYMENT AND OCCUPATION

Employer_____ Position:_____
Contact Person & Telephone: _____
If Self-Employed, Name of Business:_____

Spouse/Domestic Partner Employer_____ Position:_____
Contact Person & Telephone:_____
If Self-Employed, Name of Business:_____

CURRENT MONTHLY INCOME
Wages or Income from Employment_____
(attach copies of check stubs or W-2's)

Additional: Other Income:	Patient	Spouse/Domestic Partner
Interest/Dividends	_____	_____
Real Estate/Property	_____	_____
Social Security	_____	_____
Other (Specify)	_____	_____
Alimony or Support	_____	_____
Subtract: Alimony/Support Paid	_____	_____
Equals: Current Monthly Income	_____	_____

Total Current Monthly Income
(Patient + Spouse/Domestic Partner) _____

By signing this form I agree to allow Patients' Hospital of Redding to verify the above information including credit history and I may be required to submit proof (W-2's/Income Tax Forms) of the information I am providing. Failure to complete the form or sign it will result in denial of benefits under this program:

Signature of Patient or Guarantor:_____***Date:***_____

Signature of Spouse/Domestic Partner:_____***Date:***_____

NEW: 02/07
REVISED: 11/07
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