

Hospital Financial Assistance Application

Patient Name: _____ Admission# _____
 Address _____ Phone _____

Dependents and Income

Name	Birthdate	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Monthly Family Income

Father's Employment _____	Worker's Comp _____
Mother's Employment _____	Social Security _____
Dividends, Interest _____	Unemployment _____
Retirement Income _____	Public Assistance _____
Alimony _____	Other (specify) _____
Child Support _____	Grand Total \$ _____

All Income from Household must be reported

Proof of Income:

If you filed a federal income tax return:

- Federal income tax return (1040) from last 2 years, including all schedules and attachments
- W-2 Form showing wages and earnings

If you did not file a federal income tax return:

- Two (2) most recent paycheck stubs
- Two (2) most recent check stubs from SSI, child support, unemployment, disability, alimony or other qualified payments
- Two (2) consecutive bank statements

Monetary Assets

Cash on hand/Money in bank, savings, etc. \$ _____
 Stocks/bonds/securities (Cash Value) \$ _____
 Cash Value of real estate \$ _____

Monthly Expenses

Automobiles	Car "A"	Car "B"	Car "C"
Year _____	_____	_____	_____
Make _____	_____	_____	_____
Model _____	_____	_____	_____
Balance Owing _____	_____	_____	_____
Rent/Mortgage _____	_____	_____	_____
Other (specify) _____	_____	_____	_____

I affirm that the above information is true and correct and authorize HealthBridge Children's Hospital to obtain and verify all information reported above including but not limited to my account information from financial or commercial institutions, IRS, employers and other entities for the purpose of determining financial assistance eligibility for the above hospital admission.

Applicant's Signature _____ Date _____

Hospital Representative _____ Date _____