Newport Bay Hospital

NEWPORT BAY HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

DEMOGRAPHIC INFORMATION

PATIENT NAME	RESPONSIBLE PARTY NAME (IF DIFFERENT)
DATE OF BIRTH / SOCIAL SECURITY#	DATE OF BIRTH / SOCIAL SECURITY#
STREET ADDRESS / HOW LONG	STREET ADDRESS / HOW LONG
CITY, STATE, ZIP / OWN/RENT	CITY, STATE, ZIP / OWN/RENT
HOME PHONE / CELL PHONE	HOME PHONE / CELL PHONE
EMPLOYER NAME / HOW LONG	EMPLOYER NAME / HOW LONG
EMPLOYER STREET ADDRESS	EMPLOYER STREET ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
PHONE / CONTACT PERSON	PHONE / CONTACT PERSON
GROSS MONTHLY SALARY $ / OTHER INCOME $	GROSS MONTHLY SALARY $ / OTHER INCOME $
PATIENT SPOUSES NAME	RESPONSIBLE PARTY SPOUSES NAME
SPOUSES DATE OF BIRTH / SOCIAL SECURITY #	SPOUSES DATE OF BIRTH / SOCIAL SECURITY #
SPOUSES EMPLOYER NAME / HOW LONG	SPOUSES EMPLOYER NAME / HOW LONG
EMPLOYER STREET ADDRESS	EMPLOYER STREET ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
PHONE / CONTACT PERSON	PHONE / CONTACT PERSON
GROSS MONTHLY SALARY $ / OTHER INCOME $	GROSS MONTHLY SALARY $ / OTHER INCOME $
NAME AND AGES OF ALL DEPENDENTS IN HOUSEHOLD	NAME AND AGES OF ALL DEPENDENTS IN HOUSEHOLD

EXPENSES

INDEBTED TO TYPE/NATURE OF DEBT	CREDIT LIMIT	LOAN AMOUNT	CURRENT BALANCE	MONTHLY PAYMENT
UTILITIES				

FINANCIAL/ASSETS

CHECKING ACCOUNT NUMBER	NAME OF BANK	BRANCH ADDRESS	BALANCE
SAVINGS ACCOUNT NUMBER	NAME OF BANK	BRANCH ADDRESS	BALANCE
AUTOMOBILE (DESCRIPTION)	NAME OF BANK	BRANCH ADDRESS	PRESENT VALUE
AUTOMOBILE (DESCRIPTION)	NAME OF BANK	BRANCH ADDRESS	PRESENT VALUE
HOME	MORTGAGE HOLDER	ADDRESS	PRESENT VALUE
LIFE INSURANCE (NAME)	FACE VALUE	AGENT NAME	CASH VALUE
RETIREMENT PLAN	NAME OF BANK/PLAN	ADDRESS	PRESENT VALUE
OTHER SAVINGS/INVESTMENTS	NAME OF BANK/PLAN	ADDRESS	VALUE
OTHER SAVINGS/INVESTMENTS	NAME OF BANK/PLAN	ADDRESS	VALUE

I am requesting financial assistance for services provided by Newport Bay Hospital as I am unable to pay for the services which I am being billed. I do not have or qualify for any insurance, third party payor or have a compensable injury claim filed other than the ones Newport Bay Hospital has on file.

I/We certify the above information is complete and accurate to the best of my/our knowledge. I/We authorize Newport Bay Hospital to contact all of the above employers, creditors, financial institutions, credit reporting agencies and any other party named above to verify the accuracy of the information provided above.

I/we understand that failure to provide accurate and complete financial information may result in denial of any financial assistance for which I have submitted this application.

Signature of Applicant _____ Date _____

Signature of Spouse/Co-Applicant _____ Date _____

Signature of Hospital Representative _____ Date _____