Dear Patient/Responsible Party,

We are providing this application because you may qualify for our ***Financial Assistance Program.***

The attached form applies to hospital bills you received at this facility, and other medical bills you or your family may have incurred throughout the year.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom and return the completed application within thirty (30) days of receipt.

Inpatient Visits, Including Medicare Patients: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with **one of the following** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below:

Federal Income Tax Return
State Income Tax Return
Last 3 Employer Pay Stubs

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our charity determination by letter. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Remember: If you return this form, your bill may be included in our Financial Assistance Program

FINANCIAL ASSISTANCE APPLICATION

_____ *Application for Charity Assistance (complete Sections 1 & 3)*
_____*Application for Discount Payment Plan (complete Sections 1, 2 & 3)*

Section 1 (to be completed for applying for Financial Assistance or Discount Payment Plan)

Hospital Name_____ Account Number_____
Patient Name_____ Social Security Number_____
Responsible Party Name_____ Social Security Number_____

Dependents in Household
(Include your spouse, children under 18 and all others claimed on your tax return.)

Name (First, Middle and Last Name, if different than Patient)	Age

Employment (Patient/Responsible Party)

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes) _____
If unemployed, date last worked_____

Spouse Employment

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Other Income

	Patient	**Spouse**
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bond, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Section 2 (to be completed for Discounted Payment Plan)

Monthly Family Household Expenses

Housing	Essential Expense Amount
Mortgage or rent	
Second mortgage or rent	
Condo or association fees	
Insurance	
Electricity/gas	
Water/sewer	
Waste removal	
Maintenance/repairs	
Lawn care	

Phone/cell phone	
Internet	
Cable/satellite	
Other	

Food and Laundry	Essential Expense Amount
Groceries	
Laundry and cleaning	

Transportation	Essential Expense Amount
Car payment 1	
Car payment 2	
Auto insurance	
Gas	
Parking	
Bus/taxi fare	
Maintenance/repairs	
Licensing/tags	
Other	

Taxes	Essential Expense Amount
Federal	
State	
Local	
Other	

Personal	Essential Expense Amount
Clothing	
Personal care	
Child care	
Elder care	
Professional fees (legal, tax)	
Alimony	
Child support	
Other	

Health Care and Insurance	Essential Expense Amount
Medical services	
Dental services	
Prescriptions and medications	
Health insurance	
Long-term care insurance	
Life insurance	
Other	

Total Income: _____
Total Essential Expenses: _____

Section 3 (to be completed for Financial Assistance or Discount Payment Plan)

Have you applied for Medicaid or any other State/County Assistance? _____
If yes and known, Case Number: _____ Date Applied: _____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature_____ Date_____