Financial Assistance Application

"Application for Uncompensated Care/Charity/Indigent Care"
To be completed by the Financially Responsible Party. Please complete this Application in its entirety.

***Patient Information (A)*:**

Date: _____/_____/_____ Patient Name: _____

Account Number: _____ Date of Service: _____/____/____

Patient Information (B):

Patients Employer: _____

Patient Phone: (__)_____ Date of Birth: ____/____/____

Patient Address: _____ City: _____

State: _____ Zip Code: _____

Social Security Number: _____/_____/_____

Guarantor / Financially Responsible Party (C):

Guarantor Name: _____

Phone Number: (____) _____

Employer: _____

Address: _____

City: _____ State & Zip Code: _____

Social Security Number: _____/_____/_____

Household Information (D):

Number of family members living in the household: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If there are more family members than this box allows, please list them on a separate sheet of paper and attach them behind this page.

As provided for in Federal Law, I hereby request that St. Mary's Regional Medical Center make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for the charges for services provided.

Income Information:

Please fill out the following: **Total from last 12 months:**

Wages: $ _____

Social Security: $ _____

Strike Benefits: $ _____

Alimony / Child Support: $ _____

Military Allotment: $ _____

Dividends / Interest: $ _____

Pensions: $ _____

Unemployment: $ _____

Disability: $ _____

IRA: $ _____

Trust Account: $ _____

Interest Income: $ _____

Other not listed above: $ _____

Proof of Income attached: { } W-2 { } Paycheck Stubs { } Tax Return

Monthly Expenses:

House / Rent Payment: $ _____

Food: $ _____

Utilities: $ _____

Phone: $ _____

Cable / Internet: $ _____

Child Support: $ _____

Auto Expenses: $ _____

Insurance (Auto / Medical) $ _____

Credit Cards:

Credit Card Payments: $ _____

Company: _____ Balance Owing: $ _____

Credit Available: _____

Company: _____ Balance Owing: $ _____

Credit Available: _____

Company: _____ Balance Owing: $ _____

Credit Available: _____

Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

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Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

Medical Bills:

Hospital: _____

Name of Doctor: _____

Amount Owing if any: _____

Bank References:

Checking: Name / Branch: _____ Acct _____

Savings: Name / Branch: _____ Acct #: _____

Assets:

Do you own your own home: _____ Value: $_____

Do you own other property: _____ Value: $_____

Do you own your vehicles: _____ Value: $_____

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"I agree that my physician may be informed of the status of this application for uncompensated care."

"I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verifications, and property searches."

I affirm that the statements made herein are true and correct to the best of my knowledge.

Signature of applicant: _____
Date: _____/_____/_____

Witness Signature: _____
Date: _____/_____/_____

HOMELESS AFFIDAVIT (if applicable)

I, _____, hereby certify that I am homeless, and have no permanent address, no job, savings, or assets, and no other income other than potential donations from others and or General Relief benefits.

_____ _____/_____/_____

Patient/Guarantor Signature Date