

# Financial Assistance Application

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: M F

Telephones - home: \_\_\_\_\_ mobile: \_\_\_\_\_ work: \_\_\_\_\_

1. Do you have Medicaid/Medicare? .....Y N Policy #: \_\_\_\_\_

2. Do you have private health/medical insurance? .....Y N Provider: \_\_\_\_\_

3. Have you applied for assistance? .....Y N When/Where: \_\_\_\_\_

4. Do you have children younger than 18 living with you? .....Y N If "Yes," how many: \_\_\_\_\_ Ages: \_\_\_\_\_  
(if over 18 and a full-time student, please include)

If so, do they have Medicaid? .....Y N Under what household: \_\_\_\_\_

5. Are you a U.S. citizen? .....Y N

6. Are you currently working? .....Y N Last worked: \_\_\_\_\_

7. Employment history: \_\_\_\_\_

8. Household income: \_\_\_\_\_ Source: \_\_\_\_\_  
(for office use only)

## Resources

Primary Checking? .....Y N Bank: \_\_\_\_\_ Balance: \_\_\_\_\_

Secondary Checking? .....Y N Bank: \_\_\_\_\_ Balance: \_\_\_\_\_

Savings? .....Y N Bank: \_\_\_\_\_ Balance: \_\_\_\_\_

Any real estate property owned other than your home?.....Y N If yes, value: \_\_\_\_\_

# of Cars: \_\_\_\_\_ Value of cars: \_\_\_\_\_ Worker's comp/unemployment?: \_\_\_\_\_

Spouse Income? .....Y N Amount \$: \_\_\_\_\_ Source: \_\_\_\_\_

Investments? .....Y N Type/Amount: \_\_\_\_\_

Is this illness, injury, or condition the result of the negligence/acts of someone else (a third party)? .....Y N

I understand and agree that the information in this form will be relied upon in determining my eligibility for financial assistance and that incorrect, incomplete or misleading information may result in the denial or rescission of financial assistance. I further understand and agree that I have a duty to supplement the information contained in this form in the event a material change in my financial circumstances takes place prior to the final determination of my eligibility for financial assistance.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY:**  walk-in  mail  in-house  telephone

Account #: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Submitted by: \_\_\_\_\_ Date submitted: \_\_\_\_\_