

Financial Assistance Application

Date _____

Patient Name _____ Patient Account # W _____

Name of Responsible Party _____ Date of Birth _____

Relationship to Patient _____

Address _____ City _____ State _____ Zip Code _____ PH # _____

Employer _____ Phone Number _____ Length of Employment _____

Spouse Name _____ Spouse Employer _____

Number of dependents in Household _____ Age of Dependents _____

Please Check One:

Paycheck Frequency:

Patient

Spouse

Patient

Spouse

Employed

Employed

Weekly

Weekly

Unemployed

Unemployed

Bi-Weekly

Bi-Weekly

Retired

Retired

Monthly

Monthly

Disabled

Disabled

Do you own your home Yes No If Yes, list below.

Do you own any other property? Vehicles, RV's, Other real estate Yes No If Yes, list below.

Assets

Asset – Home, Vehicle, etc.	Loan Amount Outstanding

SAVINGS (CD, Money Market, IRA), Checking and Credit Union Accounts

Bank Name	City	Type of Account	Balance