FINANCIAL ASSISTANCE APPLICATION

______________________	____-____-____	___/___/___
Patient's Name	Social Security Number	DOB: Month Day Year

______________________	______________	______	________
Patient's Home Address	City	State	Zip Code

(_____) _______-__________	(_____) _______-__________	(_____) _______-__________
Home Phone Number	Cell Phone Number	Work Phone Number

PATIENT INFORMATION:

______________________	____-____-____	___/___/___
Responsible Party	Social Security Number	DOB: Month Day Year

Patient's Relationship to Applicant:

_____Self _____Spouse ____Parent/Legal Guardian ____Child ____Other: ____________________
Please Specify

____________________	__________	____________________	__________
Responsible Party/Patient Employer	Status	Spouse's Employer	Status

Total Gross Monthly Income:

Sources of Income	**Responsible Party/Patient**	**Spouse**
Wages	$	$
Social Security Payment	$	$
Unemployment Compensation	$	$
Disability Payment	$	$
Workers Compensation	$	$
Alimony/Child Support	$	$
Dividends, Interest, Rental Income	$	$
Other	$	$

Total number in Household:

____

PLEASE PROVIDE LAST FILED TAX RETURN, COPIES OF CHECKS, PAYSTUBS, OR STATEMENTS TO SUPPORT ALL REPORTED INCOME.

I certify that the information and documentation provided and that the answers given are truthful and accurate. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Memorial Healthcare.

X______________________________	______________________
Applicant Signature	Date

X______________________________	______________________
(For office use) Managers Signature	Date