Form # FIN-2288-FFE
Orig 06/05 Rev 09/14

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION

Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Cell Phone:	E-mail Address:	

EMPLOYMENT INFORMATION

Please indicate if you are Employed/ Retired/ Disabled:		
Current employer (I/A):		
Employer address:	How long?	
City:	State:	ZIP Code:
Position:	Annual income:	

HOUSEHOLD CO-APPLICANT INFORMATION

Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:

EMPLOYMENT INFORMATION

Please indicate if the co-applicant is Employed/Retired/Disabled:		
Current employer (I/A):		
Employer address:	How long?	
City:	State:	ZIP Code:
Position:	Annual income:	

ADDITIONAL HOUSEHOLD MEMBERS & INCOME

Name	DOB	Relationship to Applicant	Annual Income

ACCOUNTS RELATED TO APPLICATION REQUEST

Patient Name:	Account no.	Date of Service:	Amount:

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OTHER ASSETS OR SOURCES OF INCOME	
Description	Amount per month or value

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I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant _____ Date

Signature of co-applicant, I/A _____ Date

ELIGIBILITY DETERMINATION
(FOR OFFICE USE ONLY)

Date Received: _____ Verification Completed: Yes_____ No _____

Total household income _____

The applicant was approved for a reduction of _____% of allowable charges.

The applicant was denied for the following reason(s)

_____

Date of Determination: _____ Date Applicant Notified: _____

Individual Completing Review:

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Financial Assistance Application Check List

Verification of the following information is needed to complete your application for Financial Assistance:

Proof of Medical Assistance application may be required if applicable

- Proof of Income:
  - Household income
  - Income Tax Return (if applying in first three months of calendar year)
  - Pay Stubs for one month (for applications April through December)
  - Unemployment Compensation
  - Social Security verification
  - Pension
  - Workers Compensation
  - Sick Benefits
  - Self-Employment
  - Rental Income
  - Child Support
  - Interest or Dividends
  - Any other income into the household
  - MA162 with income information
- Proof of Assets
  - Checking Account balance
  - Savings Account balance
  - Certificate of Deposit (CD)
  - US Savings Bond
  - Stocks or Bonds
  - HRA, HAS, FSA, or any medical savings account