Financial Assistance Form

Instructions: Complete application, return within 10 days, and attach copies of:

- Tax returns and supporting schedules
- Social Security benefits (if applicable)
- On separate page describe your need for financial assistance
- Pay stubs (3 most recent)
- Bank Statements (3 months/all accounts)
- W-2's or unemployment statements

Patient Information

Patient Name ______________________________ Date of Birth ________________

Address ____

Social Security # ___________________________ Telephone ___________________

Responsible Party Information

Name & Address ____

Social Security # ___________________________ Telephone ___________________

Employer Name & Address ____

Telephone ___________________________________ Occupation _________________

Employment Length ______________________ Monthly Salary __________________

Driver's License Number __________________________ No. of Dependents ________

Spouse Information

Name & Address ____

Social Security # ___________________________ Telephone ___________________

Employer Name & Address ____

Telephone ___________________________________ Occupation _________________

Employment Length ____________________ Monthly Salary _______________ No. of Dependents _____

Family Group Living in Home

DEPENDENTS (if more than 5 dependents, use separate page)

Name ____________________ Relationship ____________ Age ______

Name ____________________ Relationship ____________ Age ______

Name ____________________ Relationship ____________ Age ______

Name ____________________ Relationship ____________ Age ______

Name ____________________ Relationship ____________ Age ______

Health Insurance Information

Insurance Company	Address	Subscriber	Eligibility Date	Policy & Group #

Assets/Expenses

Residence	Monthly Payment	Value	Unpaid Balance
Monthly Mortgage/Rent Payment	$	$	$
Second Residence/Vacation Home	$	$	$
Auto	**Year/Make**	**Monthly Payment**	**Unpaid Balance**
First Auto			
Second Auto			

Additional Income Information

Total Household Income $ ____________

Child Support $ ____________ Alimony $ ____________

Worker's Compensation $ ____________ Unemployment $ ____________

Social Security/Disability $ ____________ Unemployment Date/Length $ ____________

Rental $ ____________ Land Contract $ ____________

Dividend/Interest $ ____________ Trust Fund $ ____________

Public Assistance $ ____________ Retirement/Pension $ ____________

BANK ________________________ Location ________________

I understand this form must be completed in full and have all required documents attached when returned by me so Straith Hospital can determine if I qualify for financial assistance. If it is not complete, I will receive a written notice that describes that additional information and/or documents required. I have provided true and accurate information, and I agree that Straith Hospital may investigate this information and obtain my credit history/report.

____________________________ ____________________

Applicant Signature Date