Patient Name___________________________ Date of Birth ____________ SSN#__________

Date(s) of Service ______________________

Mailing Address: Street ____

City ___________________ State ______________Zip _________

Home Phone___________________________ Cell #________________________

Family size / number in household_______

Family Household Name(s) and date(s) of Birth

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth
1			4.		
2.			5.		
3.			6.		

Income

Type of Income	Patient Income Amount	Spouse Income Amount
Wages		
Social Security Payment		
Unemployment Compensation		
Disability		
Workers Compensation		
Alimony/Child Support		
Dividends/Interest/Rentals		
All other Income e.g. Pension		
Total		

If you have questions or need help completing this application, call:

If you have received a bill or bills from the hospital, check here: ____

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

Please send the signed completed form and supporting documents to:

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Applicant / Parent / Guardian Signature _____________________________ Date__________