

Application for Financial Assistance

PATIENT NAME: _____ **DATE:** _____

MEDICAL RECORD NUMBER: _____

Please answer all questions as completely and as accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Please list everyone in your home including the patient and complete each space by their name:

Social Security Number	Last Name	First Name	Birth Date	Relationship to you	Employer

INCOME: DOES ANYONE IN YOUR HOME INCLUDING THE PATIENT HAVE INCOME FROM THE FOLLOWING?:

Monthly Income <small>Please Circle Yes or No)</small>	Name of Person's Receiving	How Often Received	Amount After Deductions
Employment/Work	Yes No		
Farming/Self-Employment	Yes No		
Rental of Property	Yes No		
Retirement Benefits	Yes No		
Social Security Benefits	Yes No		
Supplemental Security SSI	Yes No		
Veteran's/ Other Pensions	Yes No		
Serviceman's Allotments	Yes No		
Job Corps Allotments	Yes No		
Child Support/Alimony	Yes No		
Contributions/Family, Friends	Yes No		
Unemployment Benefits	Yes No		
Worker's Compensation	Yes No		
Student Loans, Grants	Yes No		
Roomers or Boarders	Yes No		
Insurance	Yes No		
Savings or Dividends	Yes No		
Other (Babysitting, Part-time Work)	Yes No		

TOTAL MONTHLY INCOME \$ _____

PROOF OF MONTHLY INCOME AND CURRENT BANK STATEMENTS REQUIRED
 Paycheck stubs, copy of monthly benefit checks, award letters, employer wage letter, etc.

Application for Financial Assistance

File Income Tax__ (Yes) Attach a copy of your current 1040 Federal Income Tax Documents.

File Income Tax__ (No) Explain: _____

If you work __ (Yes) and do not make enough to file Income Tax, attach a copy of your W-2 Forms.

Have Checking account __ (Yes) __ (No) If you marked (Yes), attach a current copy of your Bank Statement.

Have Savings account __ (Yes) __ (No) If you marked (Yes), attach a current copy of your Savings Statement

Receive Public Assistance __ (Yes) __ (No) If (Yes), attach proof of Food Stamps & HUD.

HUD\$ _____ Per Month

Food Stamps \$ _____ Per Month

Has anyone in your home worked in the last 6 months who is not working now? If yes, list their name, the last month/year in which the person worked, and the place they worked _____

How have you been meeting your expenses for the past 6 months? _____

MONTHLY EXPENSES:

Monthly House or Rent Payment	\$ _____
Monthly Car or Truck Payments	\$ _____
Monthly Bank Loan Payments.....	\$ _____
Monthly Credit Card Payments (List minimum amount payable per month)	\$ _____
Monthly Doctor, Dentist, or Hospital Payments	\$ _____
Monthly Utilities (Electric, Gas, Water, Telephone, Cable, Etc.)	\$ _____
Monthly Food, Clothing, Car Fuel, Donations	\$ _____
Monthly Student Loan Payments	\$ _____
Monthly Child Day Care Payment	\$ _____
Monthly Child Support Payment	\$ _____
Monthly Medicine (Amount not paid by Health Insurance Plans).....	\$ _____
Insurance Premiums paid every month (Not paid through check deductions)	\$ _____
Insurance Paid every 3 months\$ _____	\$ _____
Insurance Paid every 6 months\$ _____	\$ _____
Insurance Paid every 12 months\$ _____	\$ _____
Personal & Real Estate Tax per year...\$ _____	\$ _____

TOTAL MONTHLY EXPENSES.....\$

Documentation Check List

COPY OF CURRENT BANK STATEMENT, SHOWING DIRECT DEPOSITS

PROOF OF MEDICAID EXPANSION COUNCILING / APPLICATION

PRIOR YEAR INCOME TAX FORMS

PROOF OF INCOME (ONE OF THE FOLLOWING)

SOCIAL SECURITY DECLARATION LETTER

PAYROLL CHECK STUB

STATEMENT OF SUPPORT FROM PARENTS, FRIEND, CHURCH ETC. IF

THEY ARE YOUR ONLY SOURCE OF SUPPORT.

This application will be returned/denied without the above documentation.

Please Read Before Signing

The information on this form is for the purpose of considering charity care. I certify that the information furnished is true and accurate to the best of my knowledge. I authorize Lawrence Memorial Hospital, its agent or any Credit Bureau or other Investigative Agency employed by Lawrence Memorial Hospital to investigate the references herein listed, statements made, or other data obtained from me pertaining to my credit and financial responsibility. Lawrence Memorial Hospital reserves the right to request verification or to adjust monthly living expenses for reasonableness. Applications cannot be processed without proof of income documents and will be returned to you.

Signed: _____ Date: _____

Telephone Number (Where you can be reached) Area Code _____ Number _____

Mailing

Address: _____

(Street or Post Office)

(City)

(State)

(Zip Code)