COMMUNITY HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE

HOUSEHOLD INFORMATION

Name_____ SS#_____

Spouse/Significant Other_____ SS#_____

Address_____Phone #_____

City, State, Zip _____Cell Phone# _____

Dependent Names/Ages_____

INCOME INFORMATION

Verification of income on all amounts listed below is required to complete the application process. Acceptable documentation includes but is not limited to: recent tax return, W-2s, paycheck stubs, bank statements, social security letter, or letter from employer.

SELF	SPOUSE/SIGNIFICANT OTHER
Employer_____	Employer_____
Address_____	Address_____
Phone #_____	Phone #_____
Monthly Gross Income_____	Monthly Gross Income_____

Other Monthly Income:_____ Type: _____

Other Monthly Income:_____ Type_____

(Other Income examples include: SSI, Child Support, Workman's Comp., Unemployment, Pension, Rent, Alimony, etc.)

If you do not have monthly income, please explain how you take care of your monthly expenses.

_____

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FINANCIAL INFORMATION

Banking and Investment:

Checking Balance	$_____
Savings Balance	$_____
Certificates of Deposit	$_____
Stocks/Bonds/Mutual Funds	$_____
Health Savings/Flexible Spending Account	$_____

Assets & Liabilities:

	Value	Balance Due
Primary residence	$_____	$_____
Secondary residence	$_____	$_____
Vehicle #1 Make_____Year_____	$_____	$_____
Vehicle #2 Make_____Year_____	$_____	$_____
Vehicle #3 Make_____Year_____	$_____	$_____
Other Assets (Including: Artwork, Jewelry, Recreational Vehicles, Campers, etc.)		
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
Self-employed include:		
Trade tools/equipment	$_____	$_____
Business Real Estate	$_____	$_____
Business Vehicles	$_____	$_____

Other Liabilities:

Payment to_____	for_____	$_____
Payment to_____	for_____	$_____
Payment to_____	for_____	$_____
Payment to_____	for_____	$_____

Comments: _____

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I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any other assistance which may be available for payment of my hospital charges (Medicaid, Insurance, etc.), and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by Community Hospital. I hereby grant permission to Community Hospital to investigate the information contained herein.

Signature_____Signature_____ Date_____