Financial Assistance Application

This application must be completed in its entirety before consideration for financial assistance will be made. Proof of income may be requested with this application.

Patient Name ______________________________ Age _______ SS# ____________________
Guarantor (If different) _________________________ Age _______ SS# ____________________

Address ____________________ City ____________________ State ______ Zip ________

Best Contact Number __________ Alternate Number __________ E-Mail ______________

Household Members & Gross Income

Name (First and Last)	DOB	POB	SS#	Relationship to PT	Income Type	Total
						(Per Month)
					Total Monthly Income	

Assets & Resources

Category	Description	Total Amount
Checking/Savings/Money Market	(Bank Name)	
	(Bank Name)	
Property/Home/Trailers	(Year/Make/Model, Amount Owed and Worth For each item)	
Vehicle 1	(Year/Make/Model, Amount Owed and Worth For each item)	
Vehicle 2	(Year/Make/Model, Amount Owed and Worth For each item)	
Other Sources of Income	(Social Security, Child Support/Alimony, Pension/Retirement)	
	(Parent, Friends, State Source / Program, Stocks, Bonds, Trusts)	

Do you have an attorney representing you for an injury related to the service rendered? Yes _____ No _____
If yes, please provide the name of your attorney ______________________________

Income Certification (Required)

I, ______________________________, certify that my family/household income for the past month has been $______________ and can be verified by contacting the following employer(s):

Income Source 1 ____________________ **Start Date** __________ **Phone #** ______________
Income Source 2 ____________________ **Start Date** __________ **Phone #** ______________
Income Source 3 ____________________ **Start Date** __________ **Phone #** ______________

I hereby authorize Health First to verify the information on this application by whatever means necessary. I further understand that this could mean contacting my bank, my employer and running a credit report or asset search. I understand that to be eligible for this program I must be willing to apply for any and all funds available to pay this bill. I also understand that this application can be re-evaluated at any time by Health First if deemed necessary. I further certify the information on this application is true and accurate. I understand that providing information to defraud a hospital for the purpose of obtaining goods and services is a second degree misdemeanor. Should any changes occur as to the information given by me on this application, I agree to promptly notify Health First, Inc. I agree that this application will become automatically null and void if I receive any first or third party liability insurance benefits, and any charity granted may be reversed.

Patient/Guarantor Signature ______________________________ **Date** ______________
Authorized Representative Signature ______________________ **Date** ______________
Witness Signature ______________________________________ **Date** ______________

Patient Label
-or-
Account # ______________

P2P (COLOR)

---------------For Office Use Only--------------
Submitted By:
Date:

Updated: 10/02/2012