FINANCIAL ASSISTANCE APPLICATION

Applicant Information:

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Name (first and last)____

Birth date______________________ Marital status_______________ Phone number ___________________________

Mailing address____ City______________ State_______ ZIP_______

Employer____________________________ Employment status __________ Number of hours worked per week_____

Applicant's Spouse Information:

Name (first and last)____

Birthdate ________________________________ Phone number ____

Employer____________________________ Employment status __________ Number of hours worked per week_____

Dependents:

Name ____ Birthdate ____________ Relationship _________________

Name ____ Birthdate ____________ Relationship _________________

Name ____ Birthdate ____________ Relationship _________________

Name ____ Birthdate ____________ Relationship _________________

Monthly Income:

(Fill in dollar amounts for each item listed below. Provide supporting documentation for each.)

Applicant Gross Income ______________________________

Spouse Gross Income ______________________________

Social Security benefits ______________________________

Pension/Retirement Income ___________________________

Disability Income__________________________________

Workers Comp Income_____________________________

Child Support Received ___________________________

Alimony Received _______________________________

Rental Property Income ___________________________

Self-Employment Income ___________________________

Other Income ___________________________________

No Income: Complete/sign declaration of no income form.

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested to determine eligibility. I agree to inform St Mary's Healthcare promptly of any changes in my needs, income, living arrangements or address.

✖ ____

Applicant's Signature

✖ ____

Relationship (if other than patient)

✖ ____

Date

OFFICE USE ONLY

Discount % Approved _________

Date Approved ______________

Approval Initials _____________