St. Mary's Healthcare Amsterdam

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 _____ Phone #_____
Mailing address_____ City_____ State_____ Zip_____
Employer_____Employment status_____ Number of hours worked per week_____

Applicant's Spouse Information:

Name(first and last)_____
Birthdate_____ Phone #_____
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 on dollar amounts for each item below. Provide amounts per month for each.)

Applicants gross Income_____	Child Support Received_____
Spouse Gross Income_____	Alimony Received _____
Social Security Benefits _____	Rental Property Income_____
Pension/Retirement Income_____	Self Employment Income_____
Disability Income_____	Other Income_____
Workers Comp Income _____	No Income: Complete/sign Declaration of no income

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.

_____
Applications signature

_____
Relationship (if other than patient)

_____
Date

OFFICE USE ONLY
Discount % Approved_____
Date Approved_____
Approval Initials_____