

FINANCIAL ASSISTANCE APPLICATION

Name: _____
 First Middle Last

Address: _____
 City State Zip

D.O.B: _____ Last 4 Digits of Social Security #: _____

Cell/Home Phone: _____ or Message Phone: _____

Occupation: _____ Employer: _____

Phone: _____

Do you have insurance coverage on any of your bills? _____

Have you applied for Medical Assistance from Human Services? _____

If yes, include copy of their determination letter.

If no, apply with your county's DHS and enclose a copy of their determination letter.

PRE-SUMPTIVE ELIGIBILITY:

Presumptive Eligibility: If you have already qualified for one of the following programs, please submit documentation supporting your eligibility. You do NOT need to complete the remainder of this application.

- ✓ Food Stamps
- ✓ Family Investment Program
- ✓ Limited eligibility – Emergency 3 day County & State relief programs, i.e. fuel assistance, WIC, etc.

Income: List income from all family members from the following sources:

	Monthly Amount
Gross Wages	_____
Farm or self-employment	_____
Unemployment Compensation	_____
Workman's Compensation	_____
Alimony	_____
Child Support	_____
Pensions	_____
Social Security	_____
V.A. Benefits	_____
Aid to Families with Dependent Children (AFDC)	_____
Supplemental Security Income (SSI)	_____
Rental Income	_____
Other	_____
Total Monthly Income	_____

Verification of income is required. You must supply the Business Office with a copy of your last 2 years income tax returns and a complete copy of your last 2 bank statements. Current pay stubs from all employers for all persons including children over the age of 19 that have resided in the household more than 6 months out of the last 12 months.

(Please complete next page)

Total number in household over the last 12 months _____

Dates of hospitalization that assistance is requested for: _____

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Signature

Date

**DETERMINATION OF ELIGIBILITY
OFFICE USE ONLY**

Date Application Received: _____

Total Bill: _____

_____ The Applicant is eligible for Financial Assistance

_____ Percent Assistance

_____ The Applicant's request for Financial Assistance has been denied for the following reason(s):

_____ Household income exceeds 200% of FPIG

_____ Application is incomplete

Date of Determination of Eligibility: _____

Date Applicant Notified: _____

Signature: _____

(Person making the determination)

MONTHLY EXPENSES

<u>Type</u>	<u>Monthly Amt</u>				
House Payment/Rent		Circle one:	Own	Rent	Other _____
Utilities					
Electric					
Gas					
Water, etc.					
Phone/Home					
Phone/Cell					
Cable TV					
Groceries					
Child Care					
Clothing					
Property Taxes					
Child Support					
	<u>Monthly Amt.</u>	<u>Remaining Balance</u>			
Auto:					
Auto Loan(s)					
Auto Insurance					
Auto Gas					
Auto Repair					
Life Insurance					
Health Insurance					
Other Creditors (please list)					

(Please complete next page)

<u>Type</u>	<u>Monthly Amt</u>	<u>Remaining Balance</u>
Medical Debt.		
Facility		
Doctor(s) name		
<u>ASSETS</u>	<u>DESCRIPTION</u>	<u>VALUE IN DOLLARS</u>
Cash on hand & in bank		
Stocks/bonds/CDs		
Real Estate Owned		
Automobiles		
Recreational Vehicles		
Life Insurance-cash value		
Other Assets - Itemized		