

**APPLICATION FOR FINANCIAL ASSISTANCE**



PATIENT NAME: \_\_\_\_\_

**INCOME:**

\$ _____ Total gross income for the past twelve months for ALL members of the household must be listed. Proof of income must be returned with this application - Income Tax Form 1040 or W-2 Form and a current paycheck stub with year to date income.			
Wages	\$ _____	Child Support	\$ _____
Farm or Self-Employment	\$ _____	Military Family Allotment	\$ _____
Public Assistance	\$ _____	Pension/ADC/Welfare	\$ _____
Social Security	\$ _____	Rental Income	\$ _____
Unemployment Compensation	\$ _____	Food Stamps	\$ _____
Worker's Compensation	\$ _____	Insurance Disability	\$ _____
Strike Benefits	\$ _____	Other	\$ _____
Alimony	\$ _____	Other	\$ _____

**ASSETS:**

Auto/Autos (year & make) _____	\$ _____
Land/Real Estate (other than residence) _____	_____
Stocks/Bonds/Royalties _____	_____
Savings/CDs/Money Market _____	_____
Recreation Vehicle/Boat (year & make) _____	_____

**HOUSEHOLD SIZE:**

NAME	D.O.B.	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**HOUSING ARRANGEMENTS:**

_____ Buying	_____ Renting	_____ Own-Value \$ _____
Living with _____		

I understand that the information which I submit is subject to verification by Fairfield Memorial Hospital. Under penalty of perjury I declare that the information provided is true, correct, and complete.

Applicant's Signature: \_\_\_\_\_ Date of Request \_\_\_\_\_

\_\_\_\_\_ Application Approved  
 \_\_\_\_\_ Application Denied