

# SOUTH COUNTY HEALTH

## APPLICATION FOR HOSPITAL FINANCIAL AID

Any approval of this request is temporary and expires 6 months from date of approval

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

MR#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security # (if issued): \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Occupation & Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Guarantor/Spouse: \_\_\_\_\_

MR#: \_\_\_\_\_

Social Security # (if issued): \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_

**LANGUAGE:**  English  Non-English \_\_\_\_\_

**ETHNICITY:**  Hispanic  Non-Hispanic  No Ethnicity Identified

**RACE:**  Asian  American Indian/Alaska Native  Black/African American

Native Hawaiian/Pacific Islander  White  Other or Multiple Races  No Race Identified

**Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor.**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS# (if issued): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MR#: \_\_\_\_\_

Employer, Phone & Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS# (if issued): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MR#: \_\_\_\_\_

Employer, Phone & Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS# (if issued): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MR#: \_\_\_\_\_

Employer, Phone & Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS# (if issued): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MR#: \_\_\_\_\_

Employer, Phone & Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

### MONTHLY INCOME

Patient's Salary & Wages: \_\_\_\_\_

Spouse's Salary & Wages: \_\_\_\_\_

Guarantor's Salary & Wages: \_\_\_\_\_

Self-Employment Income: \_\_\_\_\_

Child Care Income: \_\_\_\_\_

Rental Income: \_\_\_\_\_

Unemployment Compensation: \_\_\_\_\_

Temporary Disability Insurance: \_\_\_\_\_

Child Support: \_\_\_\_\_

Alimony: \_\_\_\_\_

Workers' Compensation: \_\_\_\_\_

VA Benefits: \_\_\_\_\_

Social Security Payments: \_\_\_\_\_

Dividend & Interest Income: \_\_\_\_\_

Royalties: \_\_\_\_\_

Pensions: \_\_\_\_\_

Public Assistance: \_\_\_\_\_

Other: \_\_\_\_\_

**MONTHLY INCOME:** \_\_\_\_\_

**ANNUAL INCOME:** \_\_\_\_\_

### ASSETS

Savings: \_\_\_\_\_

Checking: \_\_\_\_\_

Certificates of Deposit (CDs): \_\_\_\_\_

Money Market Accounts: \_\_\_\_\_

Savings Bonds: \_\_\_\_\_

Stocks: \_\_\_\_\_

Bonds: \_\_\_\_\_

Mutual Funds: \_\_\_\_\_

IRAs: \_\_\_\_\_

401(k)s: \_\_\_\_\_

403(b)s: \_\_\_\_\_

457s: \_\_\_\_\_

Cash-In Value Life Insurance: \_\_\_\_\_

Personal Property: \_\_\_\_\_

2nd Home & Rental Property: \_\_\_\_\_

2nd Motor Vehicle: \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Hospital Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_