



CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ Date of Birth: _____
 Guarantor Name: _____ Account # (s): _____
 Address: _____
 Daytime phone/message: _____ Cell phone: _____
 E-mail address: _____

HOUSEHOLD MEMBERS					
Name:	Age:	Relation:	Name:	Age:	Relation:

HOUSEHOLD MONTHLY INCOME				
Name:	Employer:	Hire Date:	Term Date:	Gross Monthly Income

OTHER MONTHLY INCOME			
Soc. Sec. \$ _____	Disability \$ _____	Unemployment \$ _____	Pension: \$ _____
TANF \$ _____	Child Support/Alimony \$ _____	Rental Prop. \$ _____	Other: \$ _____

BANK ACCOUNTS			
Bank Name:	Type (circle one)	Account #:	Balance:
	Savings/Checking		
	Savings/Checking		

OTHER ASSETS	
<i>(STOCKS, BONDS, TRUSTS, 401K, LIFE INSURANCE CASH VALUE, IRA, CD, INVESTMENTS, ETC)</i>	
Type: _____	Value: _____

MONTHLY EXPENSES			
Rent/Mortgage	\$ _____	Credit Card(s)	\$ _____
Utilities	\$ _____	Food	\$ _____
Auto Payment	\$ _____	Child Care	\$ _____
Auto Insurance	\$ _____	Medical Expense	\$ _____
Insurance premium	\$ _____	Pharmacy Expense	\$ _____
Cellular/ Telephone	\$ _____	Other	\$ _____
Gas	\$ _____	Other	\$ _____
Total Monthly Expenses:		\$ _____	

Examples of Documents that could be used to support reported income:

- * Most recent tax return (including all schedules and supporting documents - i.e. W-2)
- * 3 Most Recent Payment Stubs
- * Letter from employer(s) verifying wages
- * Unemployment Compensation Form
- * If you do not have any income, letter of support and explanation of how your living expenses are paid.
- * 3 Most recent bank statements (including all accounts)
- * Letter from Social Security indicating award amount
- * Documentation of additional assets (stocks, bonds, IRA, etc)

Additional Information/ Comments to Support Need for Assistance:

I certify that all information is true and complete to the best of my knowledge. I understand that information provided will be verified and treated as personal and confidential. I further authorize Beacon Health System providers to obtain a credit report, banking information and employment information. I understand that I must provide verification of Income, dependents, bank statements, pay vouchers and tax statements. I also understand that I will be liable for full payment of any services rendered at any Beacon Health System provider if the above information is given under false pretenses.

Guarantor Signature: _____ DATE _____

Spouse signature: _____ DATE _____