Application for Financial Assistance

PATIENT INFORMATION			
Patient Name:	Date of Birth:	Telephone No.:	
Home Street Address:	City:	State:	Zip:
Employment Status (OPTIONAL):			
Family Size:	Names (If included for financial assistance):		

RESPONSIBLE PARTY INFORMATION (If different from patient)			
Patient Name:	Date of Birth:	Telephone No.:	
Home Street Address:	City:	State:	Zip:
Employment Status (OPTIONAL):			
Family Size:	Names (If included for financial assistance):		

MONTHLY INCOME

ITEM	Patient	Other	Other
Wages/Salary			
Social Security / Pension			
Interest / Dividends			
Rental Income			
Unemployment			
Disability			
Other			
TOTAL			

REQUIRED SUPPLEMENTAL DOCUMENTATION

When submitting this application, please also provide one (or more, when applicable) of the following documents as verification of household income:

- IRS Tax Return from most recent year and all applicable schedules
- W-2 from most recent tax year for each working adult in the household
- Social Security Benefit Verification Letter from the most recent year for each person receiving Social Security benefits.
- Statement of weekly unemployment benefits
- Paystubs from the most recent three months for each working adult in the household.
- Self-Declaration of Income

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by Carroll County Memorial Hospital, even if financial assistance is not granted.

Patient Signature	Responsible Party Signature
Carroll County Memorial Hospital Representative	Date