Salina Regional Health Center

FINANCIAL ASSISTANCE APPLICATION

Applicant's Name ____

Address __________________________________ City ___________________ State _________ Zip ____

Telephone # (_____) ___________________ SS# _________________________ DOB ______________

Patient Account #(s) ____

Patient's Name ____________________________________ Address _____________________________

City ______________________________ State ________ Zip ______ Telephone # (____) ___________

Employer _______________________________ Position ____________________ How long? _________

Address ____________________________ State _______ Zip _______ Telephone # (___) ____________

Spouse's Name ________________________________ SS# ___________________ DOB ___________

Spouse's Employer ____ How long? ___________

Position ___________________________ Address ____

City ___________________________ State ______ Zip _______ Telephone # (____) _______________

Number of Family Members ______________ (Including you, your spouse, your children, and any one residing with you that you support. Also students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption are considered to be residing with those who support them.)

INCOME: LIST INCOME FOR YOUR FAMILY FROM:

	Gross Income Last 3 months	**Gross Income Last 12 months**
Wages		
Public and Emergency Assistance		
Social Security		
Unemployment Compensation		
Worker's Compensation		
Farm or Self Employment		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest		
Rental Property		
Other		
Total		

****Please attach proof of income (Copies of Check Stubs, w-2 Forms, Income Tax Return, etc.) ***

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EXPENSES: List all payments you make monthly and approximate amount(s) left owing. Be as specific and complete as possible.

	Who do you pay?	**Monthly Payment**	**Balance**
Rent-House Payment			
Electric/Gas			
Water			
Telephone/Internet			
Cable TV			
Food Estimate			
Car Loan			
Car Insurance			
Gas			
Credit Cards			
Health Insurance			
Life Insurance			
Prescription Meds			
Child Care			
Other			
TOTAL EXPENSES			

I hereby request that Salina Regional Health Center make a written determination of my eligibility for financial assistance. I certify the above information is true and correct. I understand that the information I submit concerning my income, expenses and family size is subject to verification by Salina Regional Health Center and I hereby authorize them to do so. I further authorize the employers-institutions to release such information. I also understand that if the information I submit is determined to be false, such a determination will result in denial of providing financial assistance, and that I will be liable for charges of services provided.

____ ____________________
Signature Date

____ ____________________
Witness Date

This document was received on the ______________ day of ________________, 20____ by

____.