Saint Vincent's Health System

FINANCIAL ASSISTANCE APPLICATION

Please complete the application to the best of your ability, and as fully as possible. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application

You must also provide proof of gross income. This may be in the form of your last three(3) pay stubs, last year's tax return, or other records documenting your year to date income.

PATIENT INFORMATION (PLEASE PRINT) **Account No.**

Patient Name:	Birth Date	Marital Status	Sex		Telephone No.
Address:	City	State	Zip		Email Address
Social Security Number:	Employer		Full Time / Part Time		How many hrs/wk
Employer Address:	City	State	Zip		Telephone No.

RESPONSIBLE PARTY OTHER THEN PATIENT

Name	Birth Date	Marital Status	Sex		Telephone No.
Address		State	Zip		Email Address
Social Security Number	Employer		Full Time / Part Time		How many hrs/wk
Employer Address	City	State	Zip		Telephone No.

SPOUSE'S INFORMATION

Spouse's Name		Social Security Number		Birth Date
Spouse's Employer:	Address:	City	State Zip	Telephone No.

DEPENDENTS:

Name	Age	Relationship	Name	Age	Relationship

GROSS MONTHLY INCOME	
Applicant Earned Income	
Applicant Spouse's Income	
Social Security Benefits	
Pension/Retirement Income	
Unemployment Compensation	
Worker's Compensation	
Interest / Dividend Income	
Child Support	
Alimony	
Rental Property Income	
Food Stamps	
Other	
Other	
TOTAL GROSS INCOME:	**$0**

ASSETS		
Cash on Hand		
Savings Account		
Checking Account		
C.D.'s		
Securities		
Life Insurance		
Other Real Estate		
Other		
Vehicle / Make & Model:	**Year**	**Value**
Financial Settlements:		
Life Insurance		
Inheritance		
Other		
TOTAL VALUE OF ASSETS:		**$0**

MONTHLY LIVING EXPENSES	Payment	Balance
Mortgage/Rent		
Electricity		
Gas		
Telephone		
Water		
Groceries		
Cable TV		
Car Payment		
Cell Phone		
Day Care		
Child Support/Alimony		
Prescription Drugs		
Credit Cards:		
1.		
2.		
3		
Other Doctor / Hospital Bills:		
1.		
2.		
3.		
4.		
Insurance Expense:		
1. Automobile		
2. Property		
3. Medical / Life		
Other Loan Payments:		
1.		
2.		
Other Monthly Payments:		
1.		
2.		
3.		
TOTAL MONTHLY EXPENSES:	**$0**	**$0**

COMMENTS:

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative