APPLICATION FOR HOSPITAL FINANCIAL AID-*UNDERINSURED*

Any approval of this request is temporary and expires 12 months from date of approval

Hospital: ❒ Butler ❒ Kent ❒ Memorial ❒ Women & Infants Date:

Patient:	Guarantor/Spouse:
MR#:	MR#:
Date of Birth:	Social Security # (if issued):
Social Security # (if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address:	Address:
Occupation & Employer:	
Employer Address:	

Language: ❒ English ❒ Non-English

Ethnicity: ❒ Hispanic ❒ Non-Hispanic ❒ No Ethnicity Identified

Race: ❒ Asian ❒ American Indian/Alaska Native ❒ Black/Africian 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	AMT	ASSETS	AMT	MONTHLY EXPENSES/LIABILITIES	AMT
Patient's Salary & Wages		Savings		Mortgage or Rent Payment	
Spouse's Salary & Wages		Checking		Current Balance _____	
Guarantor's Salary & Wages		Certificates of Deposit (CDs)		Property Taxes if not included in mortgage payment	
Self-Employment Income		Money Market Accounts		Utilities: Gas/Electric/Oil _____	
Child Care Income		Savings Bonds		Cable/Internet _____	
Rental Income		Stocks		Phone _____	
Unemployment Compensation		Bonds		Auto Payments or Lease Payments	
Temporary Disability Insurance		Mutual Funds		Current Balance _____	
Child Support		IRAs		Credit Card Payments	
Alimony		401(k)s		Current Balance _____	
VA Benefits		403(b)s		Installment Loans	
Social Security Payments		457s		Current Balance _____	
Dividend & Interest Income		Cash-In Value Life Insurance		Auto Insurance	
Royalties		Personal Property		Homeowners Insurance	
Pensions		2nd Home & Rental Property		Medical Expenses	
Public Assistance		Additional Motor Vehicles		Groceries	
Other				Other Expenses	
MONTHLY INCOME:					
ANNUAL INCOME:		**TOTAL:**		**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: _____

FOR INTERNAL PURPOSES ONLY

Approved By: _____ **Date:** _____

Denied By: _____ **Date:** _____

Insurance Coverage: _____ **Medical Assistance:** ❒ Yes ❒ No

Services related to work injury or other type of accident: ❒ Yes ❒ No

Comments: _____

_____

Family Size: _____ **FPG Level:** _____ **%FPG:** _____

DISCOUNT (%): _____ **DISCOUNT ($):** _____

Maximum Patient Responsibility: _____