

APPLICATION FOR HOSPITAL FINANCIAL AID-UNDERINSURED

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

Hospital: <input type="checkbox"/> Butler <input type="checkbox"/> Kent <input type="checkbox"/> Memorial <input type="checkbox"/> 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: <input type="checkbox"/> English <input type="checkbox"/> Non-English		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> No Ethnicity Identified		
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American		
<input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other or Multiple Races <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Services related to work injury or other type of accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments: _____	
Family Size: _____	FPG Level: _____ %FPG: _____
DISCOUNT (%): _____	DISCOUNT (\$): _____
Maximum Patient Responsibility: _____	