Harper County Community Hospital Financial Assistance Application

Patient Name _____ Patient Account Number _____

Telephone Number _____ Social Security Number _____ Birth date (Month/Day/Year) _____

(Street Address) _____ (City) _____ (State) _____ (Zip) _____ Own/Rent Payment/Value _____

Employed (Company) _____ Name of Employer Address, Telephone Number & Contact Person . _____

Spouse Name _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's father (If patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's mother (If patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

A.Wages: Please provide the wages for each of the following persons in your household-spouse, Life partner, others contributing to income.

Patient	$_____	Circle One Hr/Wk/Month/Year	Other	$_____	Circle One Hr/Wk/Month/Year
Other	$_____	Hr/Wk/Month/Year	Other	$_____	Hr/Wk/Month/Year

B. Other Resources: Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, trust funds etc. $_____.

Please provide the amount of yearly income you receive from these others resources, including interest income, dividends, rental income, etc. $_____.

C. Household Members: Please provide the number of persons in the patient's household. _____

D. Income Verification: Please provide the following documents to verify household income.

- **Paycheck Remittance (Last 2 months)**
- **Tax Return with W2's (Last 2 years)**
- **Bank Statements (Last 2 months) If you do not have a bank account a letter from your local banks will be needed verifying no bank account is held in any name claimed in this application.**
- **Proof of Participation in Governmental Assistance (medicaid, food stamps, CDIC or AFDC**
- **Social Security or Unemployment Compensation Letter Determinations letters**

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

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E. To determine the appropriate level of financial assistance available, please provide copies of all outstanding medical expenses for your family members the prior 12-months.

I understand Hospital may verify the financial information contained in this Financial Assistance Application ("Application") in connection with Hospital's evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize Hospital to request reports fro credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

_____

Signature of Patient or Responsible Party **Date**

_____

Hospital Approval/ Title