Financial Assistance Application

Patient Name: ____________________________________

Account Number: ________________ Date: ___________

Applicant	Spouse / Co-Applicant
Full Name	Full Name
SSN Birthdate	SSN Birthdate
List Dependents (Name & Age)	
Street Address Phone	Street Address (If different) Phone
City/State/Zip How Long	City/State/Zip How Long
Previous Address	Previous Address (If different)
City/State/Zip Years at Address	City/State/Zip Years at Address
Current Employer Position	Current Employer Position
Address Phone Years of Employment	Address Phone Years of Employment
Nearest Relative NOT living with you	Nearest Relative NOT living with you (If different)
Address Phone	Address Phone

(If additional space is needed, please attach a separate sheet of paper.)

Comments you feel may be important:

I OWN or am buying the following	
Cash	
Checking	
Savings	
HSA/MSA (Health, Medical, Savings acct.)	
AUTOS:	
Make: Model: Year:	
Make: Model: Year:	
Make: Model: Year:	
Value & Description of Real Estate:	
Retirement Accounts	
Stocks & Bonds	
Other Investments	
Recreational Vehicles	
Livestock	
Other Assets (Specify)	
TOTAL ASSETS	

Monthly Income	
INCOME VERIFICTION IS REQUIRED	
Applicant's Gross Income	
Applicant's Take Home Income	
Spouse's Gross Income	
Spouse's Take Home Income	
Other Sources of Income	
Alimony	
Child Support	
Food Stamps	
Pensions	
Social Security	
Unemployment	
Veteran's Benefits	
Welfare	
Workmen's Compensation	
Income from Interest, Dividends, Rents	
Other (specify)	
TOTAL INCOME	

I OWE (liabilities) the following	
Monthly Living Expenses	
Rent	
Food & Household Goods	
Insurance Auto / Homeowner	
Insurance Medical	
Electricity	
Utilities: Water / Sewer / Garbage	
Phone	
Car Expense	
Day Care Expense	
Child Support	
Pharmacy	
Other (Specify)	
TOTAL LIVING EXPENSES	

List Name of Creditor	Unpaid Balance	Monthly Payment
Real Estate Loan		
1. Auto Loan		
2. Auto Loan		
Bank Loan		
Finance Co. Loan		
Credit Union Loan		
Owing to Merchants		
1. Credit Card		
2. Credit Card		
3. Credit Card		
4. Credit Card		
Cable/Newspaper/Internet		
Student Loan		
Medical Loan		
Other Loans (specify)		
TOTAL		

PATIENT'S STATEMNT: I've answered the questions in this Financial Statement fully and truthfully. I hereby authorize St. Joseph Regional Medical Center to contact any and all persons or institutions, and/or obtain a credit report to verify my financial status at the present time.

SIGNED ____________________________________ PRINT ___________________________ DATE _______________________

Mailing Address: St. Joseph Regional Medical Center
Attn Patient Access
PO Box 816
Lewiston, ID 83501