ST. JOSEPH
Regional Medical Center

Financial Assistance Application

Patient Name: ____________________

Account Number: ____________________ Date: ___ / ___ / ___

APPLICANT	CO-APPLICANT
Full Name	Full Name
SSN Birthdate	SSN Birthdate
Age of Dependents	
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 How Long	City/State/Zip How Long
Current Employer Position	Current Employer Position
Address Phone How Long	Address Phone How Long
Nearest Relative NOT living with you	Nearest Relative NOT living with you
Address Phone	Address Phone

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

COMMENTS YOU FEEL MAY BE IMPORTANT: ____________________

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Financial Assistance Application
If you are applying for services in Outpatient Behavioral Health or the emergency department only household income and family size is required.

I OWN or am buying THE FOLLOWING		I OWE (liabilities) THE FOLLOWING		
Cash		**MONTHLY LIVING EXPENSES**		
Checking		Rent		
Savings		Food & Household Goods		
HSA/MSA (health, medical savings acct.)		Insurance Auto / Homeowner		
AUTOS: Make: Year Type		Insurance Medical Electricity		
Make: Year Type		Water/Garbage Phone		
Make: Year Type		Car Expense Day Care Expense		
Value & Description of Real Estate		Child Support Pharmacy		
Retirement Accounts:				
Stocks & Bonds				
Other Assets:				
Other Investments: Recreational Vehicles:		**List Name of Creditor**	**Unpaid Balance**	**Monthly Payment**
Livestock		Real Estate Loan		
TOTAL ASSETS		Auto Loans:		
MONTHLY INCOME		Auto Loans:		
VERIFICATION OF INCOME IS REQUIRED WITH SUBMITTED APPLICATION		Bank Loans:		
Applicant's Gross Income		Finance Co. Loan:		
Applicant's Take Home Income		Credit Union Loan:		
Spouse's Gross Income		Owing to Merchants:		
Spouse's Take Home Income		1. Credit Card:		
OTHER SOURCES OF INCOME		2. Credit Card:		
Alimony		3. Credit Card:		
Child Support		Cable/Newspaper/Internet		
Food Stamps		Collection Agencies:		
Pensions		Student Loans		
Social Security		Loans from Other:		
Unemployment		OTHER LOANS		
Veteran's Benefits				
Welfare				
Workmen's Compensation		Medical Expenses		
Income from Interest, Dividends, Rent				
Other				
TOTAL INCOME		**TOTAL**		

PATIENT'S STATEMENT: 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 ______________________________ DATE ______________

SIGNED ______________________________ DATE ______________

*****PLEASE COMPLETE BOTH SIDES.*****