ST. JOSEPH
Regional Medical Center

Financial Assistance Application

Name:	Account Number

Please provide the following information completely and accurately. Information is subject to veri cation.
Please attach a list of additional household members if there are more than ve (5) members.

Patient's Name (First, MI, Last):	Social Security Number	Total # Household Members
Address:	Telephone Numbers Home: ( ) Work: ( )	
City/ST/Zip	Responsible Party Name (First, MI, Last)	

List ALL household member names	Date of Birth	Relationship to patient	Monthly Income
1.			$
2.			$
3.			$
4.			$
5.			$

Monthly Income		**Monthly Expenses**	
Please provide proof of income W2, paycheck stubs, income tax returns, P&L statement, etc.		Rent/Mortgage/Homeowner's Insurance	$
Responsible Party's Gross Income (before taxes)	$	Utilities (Electricity/Water/Gas)	$
Other Household Gross income (before taxes)	$	Telephone	$
Investment Income (Annuities/Stocks/Dividends)	$	Child Support /Alimony Paid	$
Child Support /Alimony Received	$	Food (excluding cigarettes & alcoholic beverages)	$
Rental Property Income	$	Car Payment (loan + insurance)	$
Pension/Retirement/Unemployment	$	Gasoline	$
Social Security Income	$	Medical & Pharmacy Bills	$
Veteran Bene ts/Work Comp	$	Daycare	$
Total Monthly Income (before taxes)	$	**Total Monthly Expenses**	$
Assets		**Liabilities**	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account Balance	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's/Retirement Funds	$	Auto Loan Balance	$
Value - Auto/Boat/Motorcycle	$	Total Medical Bills (attach list)	$
Other	$	Real Estate Taxes	$
Total Value of Assets	$	**Total Liabilities**	$

I certify that the information provided above is an accurate and true representation of my nancial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of nancial assistance at St. Joseph Regional Medical Center. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by St. Joseph Regional Medical Center will result in the denial of this application. I also authorize St. Joseph Regional Medical Center to check my credit history.

_____ _____

Signature of Patient (Responsible Party) Date