870-886-1264

Application for Financial Assistance

PATIENT NAME: ______________________________ **DATE:** ______________

MEDICAL RECORD NUMBER: ______________________________

Please answer all questions as completely and as accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Please list everyone in your home including the patient and complete each space by their name:

Social Security Number	Last Name	First Name	Birth Date	Relationship to you	Employer

INCOME: DOES ANYONE IN YOUR HOME INCLUDING THE PATIENT HAVE INCOME FROM THE FOLLOWING?:

Monthly Income Please Circle Yes or No)		Name of Person's Receiving	How Often Received	Amount After Deductions
Employment/Work	Yes No			
Farming/Self-Employment	Yes No			
Rental of Property	Yes No			
Retirement Benefits	Yes No			
Social Security Benefits	Yes No			
Supplemental Security SSI	Yes No			
Veteran's/ Other Pensions	Yes No			
Serviceman's Allotments	Yes No			
Job Corps Allotments	Yes No			
Child Support/Alimony	Yes No			
Contributions/Family, Friends	Yes No			
Unemployment Benefits	Yes No			
Worker's Compensation	Yes No			
Student Loans, Grants	Yes No			
Roomers or Boarders	Yes No			
Insurance	Yes No			
Savings or Dividends	Yes No			
Other (Babysitting, Part-time Work)	Yes No			

TOTAL MONTHLY INCOME $ ______________________

PROOF OF MONTHLY INCOME AND CURRENT BANK STATEMENTS REQUIRED
Paycheck stubs, copy of monthly benefit checks, award letters, employer wage letter, etc.

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File Income Tax__ (Yes) Attach a copy of your current 1040 Federal Income Tax Documents.
File Income Tax__ (No) Explain: ____
If you work ___ (Yes) and do not make enough to file Income Tax, attach a copy of your W-2 Forms.
Have Checking account ___ (Yes) ___ (No) If you marked (Yes), attach a current copy of your Bank Statement.
Have Savings account ___ (Yes)___ (No) If you marked (Yes), attach a current copy of your Savings Statement
Receive Public Assistance __ (Yes) __ (No) If (Yes), attach proof of Food Stamps & HUD.

HUD $ _____________ Per Month Food Stamps $ _________________ Per Month

Has anyone in your home worked in the last 6 months who is not working now? If yes, list their name, the last month/year in which the person worked, and the place they worked_______________________________________

How have you been meeting your expenses for the past 6 months? ____

MONTHLY EXPENSES:

Monthly House or Rent Payment .... S________________
Monthly Car or Truck Payments .... $________________
Monthly Bank Loan Payments.. S________________
Monthly Credit Card Payments (List minimum amount payable per month) .... $________________
Monthly Doctor, Dentist, or Hospital Payments .... S________________
Monthly Utilities (Electric, Gas, Water, Telephone, Cable, Etc.) .... $________________
Monthly Food, Clothing, Car Fuel, Donations .... $________________
Monthly Student Loan Payments .... S________________
Monthly Child Day Care Payment .... $________________
Monthly Child Support Payment .... $________________
Monthly Medicine (Amount not paid by Health Insurance Plans)... $________________
Insurance Premiums paid every month (Not paid through check deductions) .... $________________
Insurance Paid every 3 months ....$ _______________ .... $________________
Insurance Paid every 6 months ....$ _______________ .... $________________
Insurance Paid every 12 months ....$ _______________ .... $________________
Personal & Real Estate Tax per year...$_______________ .... $________________

TOTAL MONTHLY EXPENSES... $________________

Documentation Check List

__COPY OF CURRENT BANK STATEMENT, SHOWING DIRECT DEPOSITS
__PROOF OF MEDICAID EXPANSION COUNCILING / APPLICATION
__PRIOR YEAR INCOME TAX FORMS

__PROOF OF INCOME (ONE OF THE FOLLOWING)
SOCIAL SECURITY DECLARATION LETTER
PAYROLL CHECK STUB
STATEMENT OF SUPPORT FROM PARENTS, FRIEND, CHURCH ETC. IF THEY ARE YOUR ONLY SOURCE OF SUPPORT.

This application will be returned/denied without the above documentation.

Please Read Before Signing

The information on this form is for the purpose of considering charity care. I certify that the information furnished is true and accurate to the best of my knowledge. I authorize Lawrence Memorial Hospital, its agent or any Credit Bureau or other Investigative Agency employed by Lawrence Memorial Hospital to investigate the references herein listed, statements made, or other data obtained from me pertaining to my credit and financial responsibility. Lawrence Memorial Hospital reserves the right to request verification or to adjust monthly living expenses for reasonableness. Applications cannot be processed without proof of income documents and will be returned to you.

Signed: ____ **Date:**___________________

Telephone Number (Where you can be reached) ..... Area Code ________ **Number** __________________________

Mailing Address: ____

(Street or Post Office) (City) (State) (Zip Code)