ThomasHealth

Financial Assistance Application

Patient Name: _____ Date: _____

This application must be completed in its entirety. If a question does not apply to you, please write not applicable or none. Any application that is incomplete will not be processed and will be returned to the applicant. Please return this form with your application.

Return to: Thomas Memorial Hospital or Saint Francis Hospital depending on where your services will be rendered.

The following documents must be provided with this application:

- Photo identification (Driver's license, passport, immigration ID card, state or federal issued ID)
- Copy of the most current income tax return
- Completed 4506-T form is taxes were not filed
- Proof of gross wages for the past 3 pay periods
- Proof of social security, unemployment, workers compensation payments
- Most recent property taxes
- Investment and stock statements
- Other monthly income (child support, rental income, pension, etc)
- Most current 3 months of bank statements
- If you do not have any income, a notarized letter of support will be required from the person(s) providing support.

Application for Financial Assistance

Applicant Name: _____ Phone: _____

Address: _____ Cell : _____

City State Zip

_____ Email: _____

Spouse/Domestic Partner: _____ State of Residence:_____

Please provide the date of services at Thomas Health _____

Do you currently have health insurance?	Yes No
Are you currently employed?	Yes No
Are you disabled?	Yes No
Do you collect unemployment?	Yes No

Dependents in Household

(This includes spouse, domestic partner, children others in household)

Dependent Name	Date of Birth	Social Security Number	Health Insurance

Total number of Household Members _____

Employment History
List all employers during the last 3 months, beginning with the most current.

Applicant:	
Employer Name: Employer Address:	From: To:
Employer Name: Employer Address:	From: To:
Employer Name: Employer Address:	From: To:
Spouse/Domestic Partner:	
Employer Name: Employer Address:	From: To:
Employer Name: Employer Address:	From: To:
Employer Name: Employer Address:	From: To:
Other Household Member:	
Employer Name: Employer Address:	From: To:
Employer Name: Employer Address:	From: To:
Employer Name: Employer Address:	From: To:

Other Household Member:	
Employer Name:	From: To:
Employer Address:	
Employer Name:	From: To:
Employer Address:	
Employer Name:	From: To:
Employer Address:	

Assets

(This section must be completed as part of the application for all household members)

Bank/Credit Union Accounts: savings, checking, IRA's, CD's, vacation club, Christmas club, etc.

Account Owner	Bank Name and Address	Account Number	Balance

Motor Vehicles

Automobile Owner	Make and Model	Model Year	Amount Owed

Stocks/Bonds/Mutual Funds

Account Owner	Type of Stock/Bond	# of shares	Value

Real Estate

Home/Land Owner	Address	Value of Property

Other Assets (Healthcare Savings Account, Flexible Spending Accounts, Whole Life Policies, etc.)

Description	Value

Gross Household Income

	Patient/Responsible Party	Spouse/Domestic Partner
Salary/Wages (Gross)		
Social Security		
Disability		
Child Support		
Alimony		
Unemployment		
Pensions		
Insurance/Annuity Payments		
Public Assistance		
Veterans Payments		
Workers Comp Payments		
Other Payments		
Self-employment-	Patient/Responsible Party	Spouse/Domestic Partner
Net Business Income		

Monthly Expenses

Please include current copies of all expenses included on this page. If you do not provide current bills, your application will not be processed.

Expense	Amount	Expense	Amount
Mortgage/Rent		Credit Cards	
Electric		Child Support	
Water		Alimony	
Phone/Cell		Other Expenses	
Auto Payment		_____	
Auto Payment		_____	
Food		_____	
Loans		_____	

Insurance Premiums	Amount	Medical/ Healthcare Expenses	Amount
House/Rental			
Automobile			
Health/Medical			
Life			

Total Monthly Expenses _____

I certify that the information provided by me in this application is correct to be best of my knowledge. I understand that if I give false information, assistance may be denied or reversed. I also understand that each date of service must be pre-approved.

_____ _____

Patient/Responsible Party Signature Date

Medical/Healthcare Expenses

Include physician, hospital and drug costs. Copies of bills must be included with application:

Provider Entity	**Amount**	**Provider Entity**	**Amount**
Provider Entity	**Amount**	**Provider Entity**	**Amount**

Total Healthcare Expenses:_____

Comments:_____
_____
_____
_____
_____
_____

For Thomas Health Staff Use:

Total Income $ _____
Total Assets $ _____
Total Expenses $ _____

_____
_____
_____