



DATE _____

****APPLICATION FOR FINANCIAL ASSISTANCE****

Patient's Social Security # _____ Primary Account #: _____
 Patient's Name: _____ Phone #: _____
 Address: _____
 Employer: _____
 Work Phone #: _____ Salary Per Month: _____
 Marital Status: _____ Spouse's Name: _____
 Spouse's Employer: _____
 Spouse Work #: _____ Salary Per Month: _____
 Other Income: _____ Food Stamps(include proof/letter): _____ Total Income: _____

Documents of HOUSEHOLD income MUST include the following:

- Paycheck Stub (last 2/ most recent) or COMPLETED Federal Income Tax Return (most recent year) 1040EZ, 1040A and Schedule C for business owners
- Social Security
- Child support
- State/ County Indigent Health Program
- AFDC/WIC

ASSETS

Checking Account \$ _____ Name of Bank _____
 Savings Account \$ _____ Name of Bank _____
 Stocks \$ _____ Bonds \$ _____
 Money Market accounts (not related to retirement program) \$ _____
 Property or Real Estate (other than primary residence) \$ _____

HOUSEHOLD EXPENSES IN DETAIL

Home Mortgage or Rent: _____ Lot Rent: _____ Insurance: _____
 Car or Truck Payment: _____ Make: _____ Year: _____ Insurance: _____
 Car or Truck Payment: _____ Make: _____ Year: _____ Insurance: _____
 ATV: _____ Make: _____ Year: _____ Insurance: _____
 Boats/Recreational Vehicles: _____

MONTHLY NECESSITIES:

******PLEASE BE SURE TO PROVIDE PROOF OF UTILITY BILL******

Phone: _____ *Electric: _____ Food: _____ Water: _____ Gas (propane): _____
 Life Insurance: _____ Health Insurance: _____ Daycare: _____ Medicine: _____ Medical Bills: _____
 Other Monthly Expenses: _____

CREDIT CARDS

Card: _____ Balance: _____ Monthly Payment: _____
 Card: _____ Balance: _____ Monthly Payment: _____

List **ALL** members in the household and their ages: _____

I certify that the information contained herein to be true and correct to the best of my knowledge. I understand that falsification of information given will result in the denial of this claim and any other charity awards granted to me or the patient named in this application. I do not have the resources available to pay for the services relative to the account(s) referred to in this application. I also understand that my signature authorizes Southeast Alabama Medical Center to obtain a copy of my credit report from any Credit Reporting Agency.

Signature of Responsible Party _____

Date _____

TO BE COMPLETED BY THE PATIENT ACCOUNTS OFFICE

All Accounts at the Medical Center # _____ # _____ # _____ # _____
 All Accounts at the Collections Office # _____ # _____ # _____ # _____
 Total Monthly Income: _____
 Total Monthly Household Expenses: _____
 Monthly Net Income: _____

PT REP _____

******ALL REQUESTED INFORMATION DUE 30 DAYS FROM DATE STAMPED ON APPLICATION******