(TODAY'S 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
-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******