FINANCIAL ASSISTANCE APPLICATION

Today's Date: _____

____Financial Assistance for Putnam County Hospital
____Financial Assistance for Putnam County Physician Practices

Section 1: Personal Information

Patient Name: _____Responsible Party: _____

Address: _____

Contact numbers: _____

Number in Family: _____ Marital Status: _____ Date of Birth:_____

List everyone currently in your family and how you are related:

_____

_____

_____

_____

Section 2: Income Information

Earned Income-Employer (anyone in the family):_____
_____

Self-Employment Income (anyone in the family): _____
_____

Unearned Income (Social Security, Pension, Child Support, Money from another person, unemployment, etc): _____

Section 3: Expenses Information

Child Support Paid Monthly: _____ Child Care Paid Monthly: _____

Medical Bills Owed to other Places: _____ College Expenses: _____

Certification Statement

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital and/or physician practice bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided on this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance provided to me may be reversed, and I will be responsible for the payment of the bill.

Signature: _____ Date: _____

HOUSEHOLD MONTHLY INCOME

SUPPLY COPIES OF SUPPORTING DOCUMENTS

WAGES	$	VA BENEFITS	$
TIPS	$	CHILD SUPPORT RECEIVED	$
SELF-EMPLOYMENT	$	MONEY FROM ANOTHER PERSON	$
INCOME FROM RENT	$	FOOD STAMPS	$
SOCIAL SECURITY	$	COLLEGE INCOME	$
PENSION	$	OTHER INCOME	$
UNEMPLOYMENT	$		

Revised: 05/01/16