



Financial Assistance Application

- Clinton
- Health Alliance
- Marlborough
- UMMMC

**1. PATIENT INFORMATION**

Print your full name, address and contact information for the person requesting assistance.

Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_  
Number and Street

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status:  Single  Married  Divorced Home Phone No.: (\_\_\_\_) \_\_\_\_\_ Other Phone No.: (\_\_\_\_) \_\_\_\_\_

**2. FAMILY MEMBERS**

List all family members in your household.

Please provide the following information for all of the people in your immediate family who live in your home. Family is defined as the patient, the patient’s spouse, and all of the patient’s children under 18 (natural or adoptive) who live in the patient’s home. If the patient is under the age of 18, the family shall include the patient, the patient’s natural or adoptive parent (s), and the parent (s) children under 18 (natural or adoptive) who live in the patient’s home.

Name of family members	Date of Birth	Relationship	Social Security #
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

**3. WAGES**

Please provide documentation of all wages listed.

Family Member	Amount	How often received?
1.	\$	
2.	\$	
3.	\$	
4.	\$	
5.	\$	
6.	\$	

#### 4. OTHER INCOME

Please provide documentation of all income listed.

Type of Income	Household member receiving Benefit	Amount	How often received? (circle one)
Social Security		\$	Weekly, Monthly, Annually
Unemployment		\$	Weekly, Monthly, Annually
Pension		\$	Weekly, Monthly, Annually
Disability Funds		\$	Weekly, Monthly, Annually
Veteran's Benefits		\$	Weekly, Monthly, Annually
Child Support		\$	Weekly, Monthly, Annually
Alimony		\$	Weekly, Monthly, Annually
Worker's Comp		\$	Weekly, Monthly, Annually
Net Rental Income		\$	Weekly, Monthly, Annually
Self-Employment Income		\$	Weekly, Monthly, Annually
Trust Income		\$	Weekly, Monthly, Annually
Other		\$	Weekly, Monthly, Annually

#### 5. COMMENTS/AFFIDAVIT OF SUPPORT

Use this section for additional information or your statement of support.

If you reported \$0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

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#### 6. HEALTH INSURANCE INFORMATION

Please provide information on Health Insurance Coverage.

Did you have health insurance at the time of your service? If yes, please provide your insurance information and a copy of your insurance card.  Yes  No

Insurance Company Name	ID Number	Subscriber Name	Effective Date
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**By my signing below, I certify that everything I have stated on this application and on any attachments is true to the best of my knowledge.**

I agree to provide additional documentation upon request to determine my eligibility.

I am aware that falsification of any information provided may result in a denial of financial assistance.

I agree to tell the hospital of any change in my income, family size, health insurance coverage, or other information that may change my eligibility for Financial Assistance.

Signature of Applicant/Guarantor: x \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Authorized Representative: x \_\_\_\_\_ Date: \_\_\_\_\_