



**FAMILY INCOME**

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	-----
Retirement/pension benefits	-----
Social Security benefits	-----
Public assistance benefits	-----
Disability benefits	-----
Unemployment benefits	-----
Veterans benefits	-----
Alimony	-----
Rental property income	-----
Strike benefits	-----
Military allotment	-----
Farm or self-employment	-----
Other income source	-----
<b>TOTAL</b>	-----

**LIQUID ASSETS**

	Current Balance
Checking account	-----
Savings account	-----
Stocks, bonds, CD, or money market	-----
Other accounts	-----
<b>TOTAL</b>	-----

**OTHER ASSETS**

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance -----	Approximate value -----
Automobile	Make ----- year -----	Approximate value -----
Additional vehicle	Make ----- year -----	Approximate value -----
Additional vehicle	Make ----- year -----	Approximate value -----
Additional vehicle	Make ----- year -----	Approximate value -----
Other property		Approximate value -----
<b>TOTAL</b>		-----

**MONTHLY EXPENSES**

Rent or Mortgage	-----
Utilities	-----
Car Payment(s)	-----
Credit cards(s)	-----
Car insurance	-----
Health insurance	-----
Other medical expenses	-----
Other expenses	-----
<b>TOTAL</b>	-----

Do you have any other unpaid medical bills? Yes No

For what service? -----

If you have arranged a payment plan, what is the monthly payment? -----

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within 10 days of the change.

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Applicant signature

Date -----

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Relationship to Patient