HILLSDALE HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME: ______________________________ DOB_________________

DATE OF SERVICE __________________________ ACCOUNT #________________

SECTION I. GUARANTOR INFORMATION

GUARANTOR NAME _________________________________DOB_______________

ADDRESS ____

SOCIAL SECURITY NO. ___________________ TELEPHONE _________________

PRESENT EMPLOYER ____

ADDRESS ____

DATE EMPLOYED _______________________ TELEPHONE __________________

MONTHLY GROSS SALARY $________________________

SPOUSE NAME _____________________________________DOB________________

ADDRESS ____

SOCIAL SECURITY NO. ___________________ TELEPHONE _________________

PRESENT EMPLOYER ____

ADDRESS ____

DATE EMPLOYED ______________________ TELEPHONE ___________________

MONTHLY GROSS SALARY $_______________________

OTHER INCOME (INTEREST, DIVIDENDS, RENT, DEPENDENT'S INCOME, UNEMPLOYMENT, SOCIAL SECURITY, ETC.)

SOURCE: AMOUNT FREQUENCY

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PLEASE LIST ALL RESIDENTS LIVING AT THE ABOVE ADDRESS:

1. ______________________________ RELATIONSHIP ___________ DOB__________

2. ______________________________ RELATIONSHIP ___________ DOB__________

3. ______________________________ RELATIONSHIP ___________DOB__________

4. ______________________________ RELATIONSHIP ___________DOB__________

5. ______________________________ RELATIONSHIP ___________DOB__________

6. ______________________________ RELATIONSHIP ___________DOB__________

SECTION II. ASSETS

PRIMARY RESIDENCE

LANDLORD OR MORTGAGE LENDER ______________________________________

TELEPHONE ____________________ MONTHLY PAYMENT $_________________

PURCHASE DATE _______________ PURCHASE PRICE $_____________________

ESTIMATED EQUITY $________________________

OTHER REAL ESTATE

ADDRESS ____

LANDLORD OR MORTGAGE LENDER ___________________________________

TELEPHONE ____________________ MONTHLY PAYMENT $________________

PURCHASE DATE ______________ PURCHASE PRICE $____________________

ESTIMATED EQUITY $_________________________

BANK ACCOUNTS/CREDIT UNION ACCOUNTS

SAVINGS ACCOUNTS: ACCT. NO. BALANCE

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CHECKING ACCOUNTS: ACCT. NO. BALANCE

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OTHER ASSETS (STOCKS, BONDS, CD'S CREDIT UNION, LAND, RECREATION VEHICLES, ETC.)

DESCRIPTION BALANCE

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SECTION III. HOUSEHOLD EXPENSES

MONTHLY EXPENSES

HOME RENTAL $_______________

UTILITIES $_______________

ROUTINE EXPENSES $_______________
(FOOD, CLOTHING, ETC)

MEDICAL EXPENSES $_______________

AUTO PAYMENT $_____________

INSURANCE $_____________

OTHER $____________
(PLEASE EXPLAIN)

SECTION IV. REQUIRED ATTACHMENTS

Denial Letter from Medicaid

Most recent W-2 and Federal and State Tax Return

Proof of all unearned income, Social Security, Pensions, etc.

Last (3) paycheck stubs from employment for guarantor and spouse

Copy of Checking Account Statement

Copy of Savings Account Statement

Copy of Driver's License

Copy of Social Security card

Copy of current utility bill

SECTION V. AUTHORIZATION AND AGREEMENT

I hereby submit the above statement for the purpose of allowing Hillsdale Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs, and to hereby authorize Hillsdale Hospital to verify this information as necessary, which may include a credit bureau report, employment and/or income verification, and appropriate supporting documents.

I attest that the above information and all income documentation provided are complete and accurate as shown. I realize that should, at any time, any of this information prove to be false, all Charity Care grants awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial Charity Care grant, which may be awarded.

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Patient/Guarantor Signature   Date

____

Spouse Signature   Date

FOR OFFICE USE ONLY

Annual Income ________________________

FPL_________________________ Approved Amount_____________________

Approved __________________________ Denied _______________________________

Date ____________________________