PHELPS HEALTH
FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

Mailing Address: _____

Home Address (if different from mailing): _____

County where home is located: _____ US Citizen: _____

Daytime Phone #: _____ Evening Phone #: _____

Patient Social Security #: _____ Date of Birth: _____

Marital Status: _____ Size of Family: _____

Responsible Party: _____ Social Security #: _____

Are the accounts a result of Workman's Comp, Liability or MVA? _____

Has patient applied for Cobra, Medicaid, or any type of financial assistance? _____

If denied, why? _____

Is patient currently employed? _____ Where? _____

Employer's address and phone #: _____

Is patient's spouse currently employed? _____ Where? _____

Employer's address and phone #: _____

Is patient a full time college student? _____ Start Date & School: _____

Please list Phelps Health accounts to be reviewed for financial assistance:

Account # _____ Balance Due: $_____

Account # _____ Balance Due: $_____

Account # _____ Balance Due: $_____

Account # _____ Balance Due: $_____

Account # _____ Balance Due: $_____

Account # _____ Balance Due: $_____

INCOME & EXPENSE WORKSHEET

**If you do not have any income please attach written statement of this and explain how you pay for living expenses.

Monthly Income:	**Monthly Expense:**
Wages: Self _____	Housing _____
Wages: Spouse _____	Utilities _____
Wages: Family Members _____	Telephone _____
Self-Employment: (See attached Balance Form)	Food _____
Unemployment: _____	Gasoline _____
Pension: _____	Child Care _____
Social Security: _____	Insurance _____
Other Income:___ _____	Other Medical Bills _____
Child Support: _____	Medications _____
Food Stamps: _____	Loan Payments _____
Public Assistance: _____	Other Loans _____
Dividends, Interest, CDs: _____	Credit Cards _____
Total Income: _____	**Total Expense**: _____

Do you own or rent your home? _____ If own, property value? _____

Do you own other land or buildings? _____ If yes, property value? _____

Do you own autos, trucks, vans, campers, boats, or other equipment? _____ List below:

Type _____Year _____ Model _____ Retail Value _____

Type _____Year _____ Model _____ Retail Value _____

Type _____Year _____ Model _____ Retail Value _____

I certify that the above information is true and accurate to the best of my knowledge. I understand that this application is made so the hospital can determine eligibility and may be used as a referral to Benefit Team Services to review for other available assistance.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____