

Guarantor Patient Information (if different than pt.)

Patient Name _____

Relationship to Patient _____

Date of Birth _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Address _____

City _____

State _____

Zip _____

Employment Status (check one):

Employed____ Retired____ Disabled____ Unemployed____ Student____ Dependent____

Seasonal____

Household Information:

Number of IRS Dependents _____

Number of Other Household Members (that are not dependents not including self)

Income Information: Please list your monthly income from all sources below.

Patient Other Household Total Household

(or Guarantor) Member's Income Income

Employment _____

Pension _____

Social Security _____

Veterans Benefits _____

Workers Compensation _____

Unemployment _____

Interest / Dividends _____

Alimony or Support _____

Rental Property _____

Other (please specify) _____

Total Monthly Income _____

Please attach a copy of the following:

1) Prior year's federal income tax return

2) Pay stubs for the past 2 months

Affirmation of Financial Disclosure

Omitting information or providing fraudulent information will be cause for permanent denial.

I, _____ certify that the above information is true and complete. I understand that the information provided on this form may be verified before approval for assistance may be granted. I further certify that I have made every attempt to pay for the care received.

Signature of Patient or
Responsible Party Date

The patient/guarantor will be notified in writing within 10 days of the decision to approve or deny the application.

(For internal use only)

The applicant submitted all of the required information: Yes_____ No_____

The Sliding Fee Scale Program is: Approved_____ % _____ Denied_____

The Community Care Program is: Approved_____ % _____ Denied_____

The Medically Indigent Discount is: Approved_____ % _____ Denied_____

If denied, reason for denial:

Date applicant was provided with a copy of determination:

Signature of person making eligibility determination Date