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REQUEST FOR FINANCIAL ASSISTANCE

Date of Request:_____ Date(s) of Service(s):_____

Patient Name:_____

Person completing request if not patient:_____

Relationship to patient:_____ Telephone #:_____

Address:_____

Employer Name and Address:_____

# of persons in household:_____

INCOME: (List income for family)

	Total per Month	Total for Past 6 Months
Wages		
Self Employment or Farm		
Social Security and/or SSI		
Unemployment		
Worker's Compensation		
Welfare or Public Assistance		
Child Support &/or Alimony		
Pensions		
Any Other (Interest, rent, etc.)		
Total Income:		

A copy of your most recent tax return is required.

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ASSETS: (List assets for family)

Savings Accounts_____

Checking Accounts_____

Stocks or Bonds_____

Trusts_____

Any Other_____

I solemnly swear (or affirm) that the foregoing statements in this application are true and correct to the best of my knowledge and belief.

Signature of Applicant:_____

Office Use Only (circle one)	**APPROVED**	**DENIED**
Director/Manager of Patient Financial Services:_____ Date:_____		
Chief Financial Officer:_____ Date:_____		