FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS:
COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.

PATIENT INFORMATION:

Last Name First M.I.	SSN	DOB

Street Apt# City State Zip	Home Phone
Employer Name Street	Cell Phone
City State Zip / Monthly Income	Work Phone

Please list all "family" members who live in the patient's home.

Name	Age	DOB	Relationship to Patient	Source of Income/Employer

MEDICAID ELIGIBILITY SCREENING (check all that apply)
Disabled____ _ Blind_____ Pregnant_____ Dependent children under 18 live in your home_____
If any of the above are checked, you must apply for assistance through Medicaid before being considered for Hopedale Medical Complex's Community Care Program. If you are denied by the Medicaid Program, provide a copy of your denial with this application.

INCOME INFORMATION

Please provide the following for each employed family member if you are able, or sign the statement below.

1. A copy of most recent tax return.
   AND
2. A copy of most recent pay stub.

If you are **unemployed** with no income, what is the last date you worked_____? Also, provide a letter as to how you are surviving and meeting your daily expenses. If another party is providing these means for you, please provide a signed document from that party. The document will only be used to process this application for assistance. It does **NOT** make the other party responsible for your bill.

APPLICANT CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorized the hospital to contact third parties to verify accuracy of the information provided in this application. I understand that if I knowingly provide untrue information on this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

APPLICANT SIGNATURE:_____ **DATE**:_____

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If you have any questions regarding your application please call the Financial Counselor at **309-449-4377**