



REQUEST FOR CHARITY CARE

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

Patient Name: _____

Person completing request if not patient: _____

Relationship to patient: _____ Telephone #: _____

Address: _____ Employer: _____

_____ # of persons in household: _____

INCOME: (List income for family)

	Total Per Month	Total for Past 6 Months
Wages	_____	_____
Self Employment of 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.

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

APPROVED

DENIED

Director of Patient Financial Services: _____ Date: _____

Chief Financial Officer: _____ Date: _____