NPMR

Financial Assistance Program Application

Our hospital is committed to care for all patients regardless of their ability to pay. Patients who are unable to pay for services may be eligible for Financial Assistance. Please complete and return the following form with requested documents to the Facility Registration Department or Financial Counselor to be evaluated for Financial Assistance.

Patient Account(s) #: _____ Date of Application: _____

# of Qualified Household Members: _____ Dependent of Another: ☐ Yes ☐ No

(A Qualified Household Member includes any additional adult(s) and dependent(s) based on the tax filing status of the patient.)

PATIENT INFORMATION

Name: _____
Address: _____
City: _____
State/Zip: _____
SSN (last 4 digits): __ __ __ __
DOB: _____
Employer: _____
Address: _____
City: _____
State/Zip: _____
Work Phone: _____
Cell Phone: _____
Length of Employment: _____
Supervisor: _____

PARENT/GUARANTOR/SPOUSE

Name: _____
Address: _____
City: _____
State/Zip: _____
SSN (last 4 digits): __ __ __ __
DOB: _____
Employer: _____
Address: _____
City: _____
State/Zip: _____
Work Phone: _____
Cell Phone: _____
Length of Employment: _____
Supervisor: _____

RESOURCES

Checking: ☐ Yes ☐ No Amount: $_____

Savings (including flexible spending and health savings accounts): ☐ Yes ☐ No Amount: $_____

Bonds: $_____

Cash on Hand: $ _____

Certificate of Deposit(s): $ _____

IRA Account(s): $_____

Roth Account(s): $_____

Stock/Other Financial Investment Account(s) (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)): $ _____

Trust Fund Account(s): $_____

Vehicle 1: Yr:_____ Make:_____ Model:_____

Vehicle 2: Yr:_____ Make:_____ Model:_____

Vehicle 3: Yr:_____ Make:_____ Model:_____

Vehicle 4: Yr:_____ Make:_____ Model:_____

Vehicle 5: Yr: _____ Make:_____ Model:_____

(This includes recreational vehicles such as: boats, campers, etc.)

Patient Label

INCOME

Patient/Guarantor Wages (monthly): $_____

Spouse/Second Parent Wages (monthly): $_____

Other Income

Child Support: $_____
VA Benefits: $ _____
Workers Comp: $_____
SSI: $_____

Other Income

Child Support: $_____
VA Benefits: $ _____
Workers Comp: $_____
SSI: $_____

LIVING ARRANGEMENTS

Primary Residence:

☐ Rent: $_____ ☐ Own: $_____ ☐ Other (explain): $_____

Landlord/Mortgage Holder: _____

Phone Number: _____ Monthly Payment: $_____

Second Home/Other Property: ☐ Rent: _____ ☐ Own: _____ (check one)

Value: $_____ Loan Amount: $_____ Payment: $_____

House Rent/Mortgage Payment: $_____

Other Property Payment: $_____

Utilities: $_____ Gas: $ _____

Auto: $ _____ Loans: $_____

Medical Bills: $_____ Food: $_____

Child Support: $_____ Other: $ _____

REQUESTED AVAILABLE DOCUMENTS

Proof of Income:

☐ Last 4 paystubs
☐ Letter from employer
☐ Social Security benefits (if applicable)
☐ Last 3 months bank statements
☐ Previous year's Federal Tax Return

Proof of Expenses:

☐ Copy of mortgage payment OR
☐ Copy of rental agreement
☐ Other documents requested
☐ Copies of monthly bills

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in the denial of any financial assistance by the hospital.

Signature of Applicant: _____

Hospital Representative completing the application: _____

Financial Assistance Approval Worksheet

Hospital Name:	Date Submitted:
Patient Name:	Account Number(s):
# in Household:	Balance Due:
Total Yearly Income:	Service: OP/IP/ER
Comments:	

Check box the appropriate financial assistance being offered by the hospital.

☐ YES Approved for 100% financial assistance

☐ YES Approved for partial financial assistance _____% assistance

☐ NO Patient does not qualify for financial assistance

Hospital Representative completing this review: _____

Approved by:

_____ _____

SSC Director Date SSC CFO/VP Date

_____ _____

CFO Date CEO Date

Patient Label