APPLICATION FOR HOSPITAL FINANCIAL AID

Any approval of this request is temporary and expires 12 months from date of approval

Hospital: ◯ Eleanor Slater Hospital ◯ RISPH Date:

Patient:	Guarantor/Spouse:
MR#:	MR#:
Date of Birth:	Social Security # (if issued):
Social Security # (if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address:	Address:
Occupation & Employer:	
Employer Address:	

Language: ◯ English ◯ Non-English

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ No Ethnicity Identified

Race: ◯ Asian ◯ American Indian/Alaska Native ◯ Black/Africian American ◯ Native Hawaiian/Pacific Islander ◯ White ◯ Other or Multiple Races ◯ No Race Identified

Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor.

Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued)	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		

MONTHLY INCOME	**ASSETS**
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Self-Employment Income:	Money Market Accounts:
Child Care Income:	Savings Bonds:
Rental Income:	Stocks:
Unemployment Compensation:	Bonds:
Temporary Disability Insurance:	Mutual Funds:
Child Support:	IRAs:
Alimony:	401(k)s:
Workers' Compensation:	403(b)s:
VA Benefits:	457s:
Social Security Payments:	Cash-In Value Life Insurance:
Dividend & Interest Income:	Personal Property:
Royalties:	2nd Home & Rental Property:
Pensions:	2nd Motor Vehicle:
Public Assistance:	**TOTAL:**
Other:	
MONTHLY INCOME:	
ANNUAL INCOME:	

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Patient's Signature: _____ Date: _____

Hospital Representative's Signature: _____ Date: _____

FOR INTERNAL PURPOSES ONLY

Approved By: _____ **Date:** _____

Denied By: _____ **Date:** _____

Insurance Coverage: _____ **Medical Assistance:** ◯ Yes ◯ No

Services related to work injury or other type of accident: ◯ Yes ◯ No

Comments: _____

Family Size: _____ **FPG Level:** _____ **%FPG:** _____

DISCOUNT (%): _____ **DISCOUNT ($):** _____

Maximum Patient Responsibility: _____