

# APPLICATION FOR HOSPITAL FINANCIAL AID-UNDERINSURED

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

Hospital: <input type="radio"/> Eleanor Slater Hospital <input type="radio"/> 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: <input type="radio"/> English <input type="radio"/> Non-English		
Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> No Ethnicity Identified		
Race: <input type="radio"/> Asian <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Black/African American		
<input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> White <input type="radio"/> Other or Multiple Races <input type="radio"/> 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	AMT	ASSETS	AMT	MONTHLY EXPENSES/LIABILITIES	AMT
Patient's Salary & Wages		Savings		Mortgage or Rent Payment	
Spouse's Salary & Wages		Checking		Current Balance _____	
Guarantor's Salary & Wages		Certificates of Deposit (CDs)		Property Taxes if not included in mortgage payment	
Self-Employment Income		Money Market Accounts		Utilities: Gas/Electric/Oil _____	
Child Care Income		Savings Bonds		Cable/Internet _____	
Rental Income		Stocks		Phone _____	
Unemployment Compensation		Bonds		Auto Payments or Lease Payments	
Temporary Disability Insurance		Mutual Funds		Current Balance _____	
Child Support		IRAs		Credit Card Payments	
Alimony		401(k)s		Current Balance _____	
VA Benefits		403(b)s		Installment Loans	
Social Security Payments		457s		Current Balance _____	
Dividend & Interest Income		Cash-In Value Life Insurance		Auto Insurance	
Royalties		Personal Property		Homeowners Insurance	
Pensions		2nd Home & Rental Property		Medical Expenses	
Public Assistance		Additional Motor Vehicles		Groceries	
Other				Other Expenses	
<b>MONTHLY INCOME:</b>					
<b>ANNUAL INCOME:</b>		<b>TOTAL:</b>		<b>TOTAL:</b>	

"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: \_\_\_\_\_

<b>FOR INTERNAL PURPOSES ONLY</b>	
Approved By: _____	Date: _____
Denied By: _____	Date: _____
Insurance Coverage: _____	Medical Assistance: <input type="radio"/> Yes <input type="radio"/> No
Services related to work injury or other type of accident: <input type="radio"/> Yes <input type="radio"/> No	
Comments: _____	
Family Size: _____	FPG Level: _____ %FPG: _____
DISCOUNT (%): _____	DISCOUNT (\$): _____
Maximum Patient Responsibility: _____	