SPECIAL FINANCIAL CONSIDERATION APPLICATION

Return to:
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INSTRUCTIONS FOR COMPLETING THIS APPLICATION

IN ORDER FOR A PATIENT TO BE CONSIDERED FOR SPECIAL FINANCIAL CONSIDERATION
THIS APPLICATION SHOULD BE COMPLETED IN FULL AND THE REQUESTED DOCUMENTATION ATTACHED.
THE FORM SHOULD BE RETURNED TO ASHLEY REGIONAL MEDICAL CENTER
TO THE ATTENTION OF THE REPRESENTATIVE NAMED ABOVE.
THE INFORMATION PROVIDED WILL BE VERIFIED
AND A PROPER DETERMINATION WILL BE MADE IN A TIMELY MANNER.

PLEASE PROVIDE THE FOLLOWING DOCUMENTATION TO OUR FACILITY

THIS APPLICATION COMPLETED IN ITS ENTIRETY,
A COMPLETE COPY OF SIGNED FEDERAL TAX RETURN WITH ALL SCHEDULES FOR CURRENT YEAR,
COPIES OF PAYROLL CHECK STUBS FOR THE PREVIOUS THREE MONTHS, AND
ANY/ALL OTHER DOCUMENTATION SUBSTANTIATING INFORMATION PROVIDED.

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RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME_____MARITAL STATUS_____

ADDRESS_____CITY_____ST_____ZIP_____

SOCIAL SECURITY NUMBER_____ BIRTHDATE_____ PHONE NUMBER_____

EMPLOYER_____ PHONE NUMBER_____ DATE OF HIRE_____

ADDRESS_____ CITY_____ ST_____ ZIP_____

SPOUSE'S NAME_____ BIRTHDATE_____ SOCIAL SECURITY NUMBER_____

SPOUSE'S EMPLOYER_____ PHONE NUMBER_____ DATE OF HIRE_____

NUMBER OF CHILDREN IN THE HOME_____ THEIR AGES_____

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FOR OFFICE USE ONLY
LIST ACCOUNT INFORMATION FOR MEMBERS IN HOUSEHOLD
(FOR ADDITIONAL MEMBERS, ATTACH A SEPARATE SHEET)

PATIENT NAME	ACCOUNT NUMBER	BALANCE	DISCARGE DATE	RELATIONSHIP

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INCOME INFORMATION

	RESPONSIBLE PARTY	SPOUSE
MONTHLY WAGES (BEFORE DEDUCTIONS)	_____	_____
MONTHLY ALIMONY/CHILD SUPPORT	_____	_____
MONTHLY DISABILITY/ WORKERS COMP	_____	_____
MONTHLY PENSION	_____	_____
MONTHLY SOCIAL SECURITY	_____	_____
MONTHLY DIVIDENDS/ INTEREST	_____	_____
MONTHLY RENTAL INCOME	_____	_____
MONTHLY ESTATE/ TRUST	_____	_____
MONTHLY WELFARE/ PUBLIC ASSISTANCE	_____	_____
MONTHLY FOOD STAMPS	_____	_____
MONTHLY OTHER INCOME (PLEASE LIST)	_____	_____
LESS FICA/ STATE/ FEDERAL TAXES	_____	_____
LESS ANY OTHER DEDUCTION	_____	_____
MONTHLY INCOME TOTAL	_____	_____
COMBINED MONTHLY INCOME (Line 1, Page 4)		_____

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HAVE YOU EVER FILED FOR BANKRUPTCY? YES____ NO____ YEAR_____ DISCHARGE_____ DISMISS_____

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ASSETS

	RESPONSIBLE PARTY	SPOUSE
CASH/ CHECKING	_____	_____
INVESTMENTS/ STOCKS/ BONDS	_____	_____
SAVINGS	_____	_____
LIFE INSURANCE	_____	_____
RESIDENCE	_____	_____
OTHER	_____	_____

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MONTHLY EXPENSE INFORMATION

	BALANCE DUE	MONTHLY PAYMENT
RESIDENCE PAYMENT (RENT_____ OWN_____)	_____	_____
OTHER REAL PROPERTY (LIST_____)	_____	_____
ALIMONY/CHILD SUPPORT PAYMENT	_____	_____
VEHICLE 1 PAYMENT (MAKE_____ YEAR_____)	_____	_____
VEHICLE 2 PAYMENT (MAKE_____ YEAR_____)	_____	_____
VEHICLE 3 PAYMENT (MAKE_____ YEAR_____)	_____	_____
RECREATION VEHICLE (LIST_____)	_____	_____
OTHER VEHICLE (LIST_____)	_____	_____
MONTHLY EXPENSE TOTAL (Line 2, Page 4)		_____

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MEDICAL EXPENSE INFORMATION

MEDICAL PROVIDER NAME	BALANCE OWED	MONTHJLY PAYMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
MEDICAL EXPENSE TOTAL (Line 3, Page 4)		_____

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OTHER CREDITOR EXPENSE INFORMATION

NAME OF CREDITOR	TYPE OF LOAN	BALANCE OWED	MONTHLY PAYMENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
OTHER CREDITOR EXPENSE TOTAL (Line 4, Page 4)			_____

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OTHER MONTHLY EXPENSE

AUTOMOBILE (INSURANCE/ GASOLINE/ REPAIRS	_____
GROCERIES	_____
INTERNET/ TELEPHONE/ TELEVISION	_____
MEDICAL INSURANCE	_____
UTILITIES (ELECTRICITY/ GAS/ SEWER/ WATER)	_____
OTHER MONTHLY EXPENSE TOTAL (Line 5, Page 4)	_____

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MONTHLY FINANCIAL SUMMARY

MONTHLY INCOME TOTAL (From Page 2) _____

MONTHLY EXPENSE TOTAL (From Page 3) _____

MEDICAL EXPENSE TOTAL (From Page 3) _____

OTHER CREDITOR EXPENSE TOTAL (From Page 3) _____

OTHER MONTHLY EXPENSE TOTAL (From Page 3) _____

NET MONTHLY INCOME _____

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PATIENT CONDITIONS AND COMMENTS

PLEASE PROVIDE ANY ADDITIONAL INFORMATION AFFECTING YOUR ABILITY TO PAY FOR SERVICES PROVIDED AT OUR FACILITY.
ATTACH A SEPARATE SHEET IF NECESSARY.

HAVE YOU APPLIED FOR MEDICAID? YES_____ NO_____ IF YES AND YOU WERE DENIED OR FOUND TO BE INELIGIBLE, PLEASE EXPLAIN.

HAVE YOU ASKED FOR ASSISTANCE FROM YOUR FAMILY? YES_____ NO_____ EXPLAIN:

HAVE YOU ASKED FOR ASSISTANCE FROM YOUR CLERGY/CHURCH? YES_____ NO_____ EXPLAIN:

HOW MUCH ARE YOU ABLE TO PAY EACH MONTH? EXPLAIN:

A MINIMUM MONTHLY PAYMENT OF _____ IS REQUIRED ON MY COMBINED ACCOUNTS.

WITH THIS APPLICATION I AM REQUESTING A LOWER MONTHLY PAYMENT OF _____

I HERBY STATE THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE.

I AUTHORIZE ASHLEY REGIONAL MEDICAL CENTER TO VERIFY THIS INFORMATION, INCLUDING REQUESTING A CREDIT BUREAU REPORT.

I UNDERSTAND THAT IF ANY OF THIS INFORMATION IS DETERMINED TO BE DECEPTIVE OR FALSE,
I MAY BE DENIED SPECIAL FINANCIAL CONSIDERATION AND
I WILL BE LIABLE FOR PAYMENT OF ANY AND ALL CHARGES INCURRED FOR SERVICES RENDERED.

RESPONSIBLE PARTY'S SIGNATURE_____ DATE_____