THE PATIENT.
ABOVE ALL ELSE.®

Lake View
A member of St. Luke's

ATTACHMENT B

FINANCIAL ASSISTANCE APPLICATION FORM

Applicant/Responsible Party: _____ _____ ____
Last First MI

Patient Name: _____ _____ ___
(if different than applicant) Last First MI

Applicant Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

U.S. Citizen: Yes No **Marital Status:** Single Married Widowed Divorced

Was Medical Assistance denied? Yes No
Is applicant ineligible for Medical Assistance? Yes No
If Yes to either of the above, state reason(s) why: _____

- **Attach copy of written Medical Assistance denial letter**

Number of members in the household: _____
Complete information below on each household member

Name	Relationship to Applicant	Date of Birth	Type of Health Insurance Company. & ID#	Student (Yes/No)	Employed (Yes/No)	Primary care Dr.

INCOME INFORMATION

A. Employment

Applicant Social Security # _____ Spouse Social Security # _____

Applicant's Employer	Spouse's Employer
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**

If Self-Employed: Provide income and expenses for the most recent 3 months.

Gross Operating Income: _____ Operating Expenses: _____

B. Income Information

Monthly Income of All Household Members

Income Source Per month	Applicant	Spouse or Household Member	Household Member
Employment (Gross amount)			
Interest Income			
Social Security/SSI			
Disability			
Unemployment Compensation			
Worker's Compensation			
Pension(s)			
Child Support			
Alimony			
Public Assistance			
Military Pay			
Other:			
Other:			

Attach both of the following documentation:

- **Copies of your paycheck stubs or a written statement from your employer showing earnings for the past 3 months**
- **Copy of last year's tax return**

ASSET INFORMATION

A. Banking Information for all Household Members

- **Attach copy of the most recent statement showing balance in each account**

Bank Name:_____ Current Balance: _____

Address: _____

Primary Account Holder: _____

Bank Name:_____ Current Balance: _____

Address: _____

Primary Account Holder: _____

B. Other Investments (Stocks, Bonds, Annuities, Life Insurance cash value, etc.)

- **Attach copy of the most recent statement showing value of each investment listed**

Type of Investment	Amount	Primary Account Holder

C. Property

***Do you rent or own your home?** Rent Own (circle one)

Type of Asset	Amount
Homestead	
A. Estimated fair market value	
B. Balance on Mortgage	
Other Property	
A. Estimated fair market value	
B. Balance on Mortgage	

D. Vehicles/Recreational
(List all cars, trucks, boats, campers, motorcycles, recreational vehicles, etc.)

Item #1: Model & Year:	
A. Blue Book Value/Estimated value?	
B. Loan Balance	
Item #2: Model & Year:	
A. Blue Book Value	
B. Loan Balance	
Item #3: Model & Year:	
A. Blue Book Value	
B. Loan Balance	

OTHER INFORMATION

- **Please provide any additional information (financial or other) that would assist in evaluating your request for assistance. (Page can be included as an attachment**

- **Attach additional information if there is insufficient space on the application in any category**

- **Provide the following documentation**
  - **Copy of written denial letter from Medical Assistance**
  - **Copies of your paycheck stubs or a written statement from your employer showing earnings for the past 3 months**
  - **Copy of last year's tax return**
  - **Copies of the most recent statement showing balance in each bank account**
  - **Copies of the most recent statement showing value of each investment listed**

I understand that the information provided is subject to verification. I certify that the information on this application is true and correct to the best of my knowledge. I agree to notify this organization promptly of any changes to the information in this document.

Applicant's Signature: _____

Date: _____

Lake View Hospital
Business Office
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