



APPLICATION FOR FINANCIAL ASSISTANCE

REGION:
 MISSOURI ILLINOIS
 OKLAHOMA IOWA
 WISCONSIN

FACILITY:
 SAH CGCMC ACC SMJC SJHC SMCGMV
 BJSAH SFMV SCB SJHC (Went)
 SMJH SMHC SMM DPHC
 CGCMC SCHC SJHW SMCGC

PATIENT INFORMATION									
Patient Name					Age	Telephone No.			Patient No.
Present Home Street Address		Apt. No.	City		State	Zip Code		Rent <input type="checkbox"/> Own <input type="checkbox"/>	Live with parents Yes <input type="checkbox"/> No <input type="checkbox"/>
Social Security No.		Marital Status	Discharge Diagnosis					If pregnant, due date?	
Name & Address of Employer					How long employed?		Telephone No.		
Position/Title					Supervisor's Name				
If Unemployed, Last Date & Place of Employment					Position/Title				
RESPONSIBLE PARTY INFORMATION									
Name					Age	Relationship to Patient		Telephone No.	
Street Address if Different from Patient		Apt. No.	City		State	Zip Code			
Social Security No.		Marital Status	Family Size	Names and Ages					
Name & Address of Employer					How long employed?		Employer Telephone No.		
Position/Title					Supervisor's Name				
If Unemployed, Last Date & Place of Employment					Position/Title				
Name of Nearest Relative							Relationship		
Address							Telephone No.		
SPOUSE INFORMATION									
Name			Age	Social Security No.		Name of Employer			
Address of Employer						How long employed?		Employer Telephone No.	
Position/Title						Supervisor's Name			
If Unemployed, Last Date & Place of Employment						Position/Title			
MONTHLY INCOME					ASSETS				
ITEM	<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother		<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother		<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother		Checking Account(s) (bank & account number)		Balance
	Base Income		Overtime		Social Security		Savings Account(s) (bank & account number)		Balance
Interest/Dividends		Rental Income		Alimony/ Child Support		Other (bank & account no.) (money market, C.D., IRA)		Balance	
Unemployment		State Assistance		Food Stamps		Life Insurance (company & account number)		Value	
Pensions		Disability		Worker's Compensation		Stocks, Bonds and Mutual Funds (company)		Value	
Other		Other		Other		Automobiles/Trucks (make, model & year)		Value	
TOTAL		TOTAL		TOTAL		Other Assets (personal, livestock, machinery, motorcycles, RV)		Value	
						Real Estate (list and describe)		Present Value	
						TOTAL ASSETS:			

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, ALL ITEMS ARE REQUIRED FOR REVIEW, PLEASE PROVIDE THE FOLLOWING ITEMS:

- 1). MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX.
- 2). BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS - 3 MONTHS).
- 3). VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC.).
- 4). SIGNATURE IN ORDER TO PROCESS.

MONTHLY EXPENSES		OTHER EXPENSES	MONTHLY PAYMENT	BALANCE	PAYMENT CURRENT?												
Item	MONTHLY PAYMENT	Charge Accounts			<input type="checkbox"/> YES <input type="checkbox"/> NO												
Rent					<input type="checkbox"/> YES <input type="checkbox"/> NO												
Mortgage					<input type="checkbox"/> YES <input type="checkbox"/> NO												
Electricity					<input type="checkbox"/> YES <input type="checkbox"/> NO												
Gas/Propane					<input type="checkbox"/> YES <input type="checkbox"/> NO												
Water		Personal Loan (name & purpose)			<input type="checkbox"/> YES <input type="checkbox"/> NO												
Refuse		Automobile Loan (name)			<input type="checkbox"/> YES <input type="checkbox"/> NO												
Telephone		Real Estate Loan (name)			<input type="checkbox"/> YES <input type="checkbox"/> NO												
Cable TV		Cellular Phones, Pager			<input type="checkbox"/> YES <input type="checkbox"/> NO												
Food		Miscellaneous: (name & purpose)			<input type="checkbox"/> YES <input type="checkbox"/> NO												
Clothing					<input type="checkbox"/> YES <input type="checkbox"/> NO												
Medicine					<input type="checkbox"/> YES <input type="checkbox"/> NO												
Baby Sitter		Totals	Total Monthly Payments	Total Balance													
Transportation																	
Alimony/Child Support																	
Auto Insurance																	
SUMMARY																	
Home Insurance		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Total Monthly Income</td> <td style="width: 10%;">\$</td> <td style="width: 60%; border-bottom: 1px solid black;"></td> </tr> <tr> <td>Total Monthly Expenses</td> <td>\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Discretionary Income</td> <td>\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Monthly Payment Arrangements</td> <td>\$</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>				Total Monthly Income	\$		Total Monthly Expenses	\$		Discretionary Income	\$		Monthly Payment Arrangements	\$	
Total Monthly Income	\$																
Total Monthly Expenses	\$																
Discretionary Income	\$																
Monthly Payment Arrangements	\$																
Life Insurance																	
Health Insurance																	
Personal Property Tax																	
Real Estate Tax																	
Sub Total																	
OTHER EXPENSES																	
Will the patient be unable to work or go to school due to physical impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
If yes, what is the disabling condition or diagnosis? _____																	
How long will the patient be disabled? _____ (Please attach a statement from the doctor).																	
COMMENTS																	
PATIENT AGREEMENT																	
The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above reference for credit verification, including credit bureaus.																	
_____ Patient Signature			_____ Responsible Party or Spouse Signature														
_____ Date		_____ Facility Representative		_____ Department													