

Little Company of Mary Hospital Financial Assistance Application

Patient Name _____ Hospital ID Number V _____

Date (s) of Service _____ Insurance (if Any) _____

Balance Due \$ _____

Monthly Income:

Your Salary/Wages (Any)
i.e.; Social Security, Disability
Pension \$ _____

Spouse Salary/wages
Or Other income \$ _____

Interest
Dividend Income \$ _____

Total \$ _____

*** A copy of your most recent Federal tax return, W-2 forms must accompany this application for processing or proof of unemployment.**

Assets

Cash on Hand \$ _____

Savings Account Balance \$ _____

Checking Account Balance \$ _____

Credit Unions Balance \$ _____

Investments \$ _____

Life Insurance (Value) \$ _____

Total \$ _____

****Attach all most recent copies of banking statements to document assets**

Monthly Expenses

Rent/Mortgage \$ _____

Food \$ _____

Clothing \$ _____

Utilities \$ _____

Automobile \$ _____

Medical Care/Pharmaceuticals
\$ _____

Insurance \$ _____

Other \$ _____

Total \$ _____

***** All copies of receipts for previous 3 months expenses must accompany this application.**

Household Size

Indicate the total number of dependents in your household _____

Names/Ages of Dependants

_____	_____
_____	_____
_____	_____
_____	_____

I certify that the above information is an accurate and complete statement of my current financial status

Guarantor/Patient Date

Hospital Representative Date

Spouse Date

Charity eval