Little Company of Mary Hospital
Payment Plan 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 Income $_____

Contract Amount of monthly payment

$_____ for _____months

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

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**