Randolph Health Financial Assistance Application

Patient Account Number: _____ **Date of Application: _____**

If no account number, is this for a future service?
Expected Date: _____ Referring Physician: _____

PATIENT INFORMATION	**PARENT/GUARANTOR/SPOUSE (*circle one*)**
Name_____	Name_____
Date of Birth _____	Date of Birth _____
Address_____	Address_____
City_____	City_____
State/ZIP_____	State/Zip_____
SS#_____	SS#_____
Marital Status ___S ___M ____D ___W	Marital Status ___S ___M ____D ___W
Phone _____	Phone _____
Employer_____	Employer_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES/ASSETS

Checking: YES □ NO □ Total: $ _____
Savings: YES □ NO □ Total: $ _____
Cash on Hand $_____

Vehicle 1: Yr. _____ Make_____ Model_____
Vehicle 2: Yr. _____ Make_____ Model_____
Vehicle 3: Yr. _____ Make_____ Model_____

LIVING ARRANGEMENTS

Others in the Household

Name	Relationship	Age	Employed?	Income

Rent: _____ Own: _____Other (explain) _____

Landlord/Mortgage Holder: _____

Monthly payment $_____

Other real property owned:
Address: _____ County: _____

REQUIRED DOCUMENTS

The following documents must be attached to process you application for Financial Assistance:

- Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 check stubs (if applicable), or a letter from employer, or letter from Social Security, etc.…
- Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, utilities, cable and cell phones.)
- Other documents as requested.

*The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in a denial of any financial assistance by the hospital.

**The hospital reserves the right to run a copy of your credit report.*

_____ _____

Applicant Signature **Date Signed**

Hospital Representative Completing Application_____

Approval of Financial Assistance Write-Off Amount Approved: %_____ $_____

PFS Director _____ CFO _____