**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

# LIVING ARRANGEMENTS

Others in the Household

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship | Age | Employed? | Income |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

# REQUIRED DOCUMENTS

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

* Proof of Income: Prior year income tax return or last 4 check stubs (if applicable), or a letter from employer, or letter from Social Security, etc.
* 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/income verification.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Signature Date Signed**

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Hospital Representative Completing Application

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

PFS Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CFO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_