

4. Other Income

Please provide documentation of all income listed.

Type of Income	Household Member Receiving Benefit	Amount	How Often Received? (circle one)
Social Security		\$	Weekly, Monthly, Annually
Unemployment		\$	Weekly, Monthly, Annually
Pension		\$	Weekly, Monthly, Annually
Disability Funds		\$	Weekly, Monthly, Annually
Veteran's Benefits		\$	Weekly, Monthly, Annually
Child Support		\$	Weekly, Monthly, Annually
Alimony		\$	Weekly, Monthly, Annually
Worker's Comp		\$	Weekly, Monthly, Annually
Net Rental Income		\$	Weekly, Monthly, Annually
Self-Employment Income		\$	Weekly, Monthly, Annually
Trust Income		\$	Weekly, Monthly, Annually
Other		\$	Weekly, Monthly, Annually

5. Comments / Affidavit of Support

Use this section for additional information or your statement of support.

If you reported \$0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

6. Health Insurance Information

Please provide information on Health Insurance Coverage.

Did you have health insurance at the time of your service? No Yes

If yes, please provide your insurance information and a copy of your insurance card:

Insurance Company Name	ID Number	Subscriber Name	Effective Date
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By signing below, I certify that everything I have stated on this application and on any attachments is true to the best of my knowledge.

I agree to provide additional documentation upon request to determine my eligibility.
I am aware that falsification of any information may result in a denial of financial assistance.

I agree to tell the hospital of any change in my income, family size, health insurance coverage, or other information that may change my eligibility for financial assistance.

Applicant/Guarantor Signature_____
Printed Name_____
Date_____
Time_____
Authorized Representative Signature_____
Printed Name_____
Date_____
Time