

SPOUSE (If applicable)				
Name (First, Middle, Last)		Social Security Number	Birth Date (MM/DD/YYYY)	Phone Number:
Employment Status: Full Time Part Time Self Employed Unemployed Student Retired		Employer Name, Address, and Phone Number:		
Hire Date: (MM/DD/YYYY)	Position:	How Often Paid: Weekly Bi-Weekly Monthly Bi-Monthly	Are you claimed on another tax return? Yes No <small>If yes, provide tax return of those claiming you.</small>	
Unemployed: (MM/DD/YYYY) From: To:		Average Gross Monthly Income: \$	Monthly SSI/SSDI: \$	

DEPENDENTS (If more than 4 dependents use a separate page)				
Full Name	Relationship	Birth Date (MM/DD/YYYY)	Claimed as a Dependent on Taxes	
1.			Yes	No
2.			Yes	No
3.			Yes	No
4.			Yes	No

OTHER MONTHLY INCOME (Please attach copies of your documents to support this income)					
Other Wages	\$	Rental Income	\$	Alimony/Child Support	\$
Pension	\$	Disability Income	\$	Unemployment	\$
Misc. Income	\$	Veterans Benefits	\$	Interest/Dividends	\$

PRIMARY EXPENSES: (Not applicable to families with annual income at or below 200% of the current FPG)			
TYPE	MONTHLY PAYMENT	ESTIMATED VALUE	UNPAID BALANCE
Rental Payment	\$	N/A	N/A
Primary Home	\$	\$	\$
2 nd Mortgage	\$	\$	\$
Secondary/Vacation Home/Land	\$	\$	\$
<input type="checkbox"/> None – Please explain why you have no rent or mortgage:			

AUTO/MOTORCYCLE/RECREATIONAL VEHICLES: (Not applicable to families with annual income at or below 200% of the current FPG)			
TYPE/MAKE/MODEL/YEAR	MONTHLY PAYMENT	ESTIMATED VALUE	UNPAID BALANCE
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

ASSETS: (Not applicable to families with annual income at or below 200% of the current FPG)			
Checking Balance	\$	Savings Balance	\$
Stocks/Bonds	\$	CD	\$
401K	\$	IRA	\$
403B	\$	Other/HSA/FSA	\$

CERTIFICATION: I certify the preceding income/expense information is true and correct. Please be aware we may review the information you provided in conjunction with your credit report. I understand if I knowingly provide untrue information in the application, I will be ineligible for financial assistance and the financial assistance granted to me may be reversed and I will be responsible for the medical bills.

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED	
Patient/Responsible Party Signature	Date
Spouse (If applicable)	Date