Saint Joseph's Medical Center

FINANCIAL ASSISTANCE APPLICATION

Please Print

Patient's Name: _____

Hospital/Clinic & Account Number(s): _____

Type of Service: ____Clinic __Emergency __Inpatient____Radiology____Amb. Surg

Address	City/State/Zip	Telephone #	Cell Phone or Other Contract (Name & Phone #)
Date of Birth	Social Security #	Employer	Address / Phone #
If minor – Parent's Names	Social Security #	Employer	Address / Phone #
Family Members:	Dates of Birth:	Social Security #s	Name of Bank / Address & current balance:
Family's Annual Income:	Rent or Own? Monthly payments	Miscellaneous Other:	Credit Cards and Balance Due:

Situational Information / Please describe you current financial situation / hardships:

_____

_____

_____

Applicant Statement:

I certify that the above information is correct. I understand that the information, which I submit, is subject to verification by St. Joseph's Hospital and subject to review. Further, I will take all steps necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. I understand that if any of the information I have given proves to be untrue, the hospital may re-evaluate my financial status and take whatever action it deems appropriate.

_____ _____

Signature (Patient or Guarantor Date

_____ _____

Print Name Relationship to Patient