STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME _____ SPOUSE _____
ADDRESS _____
PHONE _____
ACCOUNT # _____ SSN: _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Relationship	Age	Name
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____
Spouse Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

Spouse	Patient		
_____	_____	Gross Pay (Before Deductions)	
_____	_____	Income from Operating Business (if Self-Employed)	Add:
_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	Other Income Interest & Dividends From Real Estate Social Security Other (Specify) Alimony or Spousal Support	Add:
_____	_____	Alimony, Support Payments Paid	Subtract:
_____	_____	Current Monthly Income	Equals

Total Current Monthly Income (Patient + Spouse) = $ _____

FAMILY SIZE

Total Family Members: _____
(Add patient, spouse, and dependents from above)

	Yes	No
Do you have health insurance?	____	____
Are you eligible for any government programs?	____	____
Do you have other insurance that may apply (such as auto policy)?	____	____
Were your injuries caused by a third party (such as during car accident)?	____	____

By signing this form, I agree to allow St. Rose Hospital to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing.

_____ _____
(Signature of Patient or Guarantor) Date

_____ _____
(Signature of Spouse) Date