FINANCIAL ASSISTANCE APPLICATION

☐ NEW ☐ RENEWAL

Date: ______________________

It is the policy of Falls Community Hospital & Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. If eligible, you or members of your family will receive a card that must be presented to registration when receiving services. You will not receive the discount, if you do not present the card.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Name ____

Address ____

City ________________ State ______ Zip Code __________

Time at this address: ______________________________

Phone Number ______________________________

Place of employment ______________________________

Emergency Contact: Name, address, phone number

HOUSEHOLD

	NAME	DATE OF BIRTH		NAME	DATE OF BIRTH
SELF:			DEPENDENT:		
SPOUSE:			DEPENDENT:		
DEPENDENT:			DEPENDENT:		
DEPENDENT:			DEPENDENT:		

INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's compensation, Social Security, public assistance, veteran's payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance from outside the household, and other misc. sources				
TOTAL INCOME				

COPIES OF TAX RETURNS, PAY STUBS, OR OTHER INFORMATION VERIFYING INCOME ARE REQUIRED BEFORE A DISCOUNT IS APPROVED.

I certify that the family size and income information shown above is correct.

Name (Print): ______________________________ Date ______________________

Signature: ______________________________

FOR OFFICE USE ONLY

Patient Name: ______________________________ Approved Discount: ______________________

Approved By: ______________________________ Date: ______________________

VERIFICATION CHECK LIST	YES	NO
Identification/Address: Driver's License, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		