LIFESPAN'S APPLICATION FOR HOSPITAL FINANCIAL AID

Any approval of this request is temporary and expires 6 months from the date of approval

Hospital:	Date:
Patient:	Guarantor:
Date of Birth:	Social Security #(if issued):
Social Security #(if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address: Own/Rent:	Home Address Own/Rent:
Occupation & Employer:	Occupation & Employer:
Employer Address:	Employer Address:
Type of ID & #	Type of ID & #
Is visit related to a work injury or Accident? Yes or No *(If yes, please attach explanation)*	
Are you being claimed as a dependent? Yes or No	
Number of Dependents (including self):	
Please provide the following information for ALL members of the family unit (if they are not listed on the Federal Income Tax Form).	
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address	Home Address:
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address	Home Address:
Monthly Income	**Assets**
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Guarantor's Salary & Wages:	Money Market Accounts:
Child Care Income:	Saving Bonds:
Rental Income:	Stocks:
Unemployment Compensation:	Bonds:
Temporary Disability Insurance:	Mutual Funds:

Monthly Income Cont.:	Assets Cont:	
Child Support:	IRAs:	
Alimony:	401(k)s:	
Workers' Compensation:	403(b)s:	
VA Benefits:	457s:	
Social Security Payments:	Cash-In Value Life Insurance:	
Dividend & Interest Income:	Personal Property:	
Royalties:	2nd Home & Rental Property:	
Pensions:	2nd Motor Vehicle:	
Public Assistance:		TOTAL:
Other:		
Monthly Income:	Total Monthly Expenses:	
Annual Income:		
IF YOU LIST NO INCOME WHAT HAS BEEN YOUR SOURCE OF SUPPORT? Use separate sheet of paper if needed.		

Please be sure to enclose a copy of your most recent Federal Income Tax Filing and the last two paycheck stubs.

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."	
Signature:	Date:

Action Taken By The Hospital

CHECK OFF LIST

Pay Stubs_______________

Food Stamp Letter_________________

Tax Returns___________________

Credit Report_________________

Other Documentation___________

Date verified with E.D.S./GPA________________

If non-Resident required documentation:____________

Date:_________________

NOT Approved:________

Reason:__________________________

Approved: ______________________

Account#: __________________

Expiration Date:_____________________________

Comments: ____

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Authorized Signature

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Administrative Approval