SULLIVAN COUNTY MEMORIAL HOSPITAL

Financial Assistance Application

Account (s) #:______________________________________

____ _______-_______-_______ _____/_____/________
Responsible Party or Guarantor | Social Security Number | DOB: Mth Day Year

____ _____________ _____________
Home Address | City | State | Zip Code

(___)__________-_____________ (___)__________-_____________ (___)__________-_____________
Home Phone Number | Cell Phone Number | Work Phone Number/Other

____ _______-_______-_______ _____/_____/________
Patient's Name | Social Security Number *(optional)* | DOB: Mth Day Year

Patient's Relationship to Applicant: ☐ Self ☐ Spouse/Partner ☐ Parent/Legal Guardian ☐ Child
☐ Other (please specify):____

Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. Check the appropriate relationship box for each dependent.

Relationship

Name	Age	Spouse/Partner	Parent	Child	Other
1. ____________________	____	☐	☐	☐	☐
2. ____________________	____	☐	☐	☐	☐
3. ____________________	____	☐	☐	☐	☐
4. ____________________	____	☐	☐	☐	☐
5. ____________________	____	☐	☐	☐	☐
6. ____________________	____	☐	☐	☐	☐

Have you been a resident of Sullivan County for the last year? ☐ Yes ☐ No

Total Gross Monthly Income for the last 30 days:

Sources of Income	Applicant/Patient	Spouse/Live-in Partner
Wages	$	$
Social Security Payment	$	$
Unemployment Benefits	$	$
Disability Payment	$	$
Workers Compensation	$	$
Alimony/Child Support	$	$
Dividends, Interest, Rental	$	$
Food Stamps, Gov. Assist.	$	$
Other	$	$

Return completed application with prior year tax return, bank statements for last two months and last two paycheck stubs. If you have special circumstances you would like considered please attach a separate letter with the explanation.

By my signature below, I certify that the information and documentation provided is an accurate and complete statement of my current financial position and give my permission to verify this information. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Sullivan County Memorial Hospital

Signature of Patient/Applicant:____ Date:_______________________