FINANCIAL ASSISTANCE POLICY APPLICATION

Account # (s)____ **Date:** ___________________

Section One: Personal Information:

1. Patient Name:__________________________2. Social Security #_________________________

3. Street Address:_________________________City, State, Zip: ___________________________

4. Guarantor:____5. Service Date: ________________

6. Phone# (home)_________________(work)_________________(cell) _____________________

7. Total Income:________________8. Family Size: ____________

Section Two: Income Criteria

Sources of Income: ________________________

Gross Salary/Wages:
One month income criteria x 12: ________________
Three months income criteria x 4: ________________
Twelve months income criteria: __________________

Documents Required:
Identification: Driver's license, SS card or birth certificate
-Income: You may provide the one month, three months or twelve months prior to date of service. Current Pay Stubs, Profit and Loss Statement if self-employed, Previous Completed Income Tax Return

In connection with your application to participate for The Financial Assistance Discount, The Valley Hospital may require some additional information to be supplied by you. This information may be necessary to complete your application.

Please sign the bottom of this form and return it with the documentation required.

____ _______________
Signature Date