



Application for Financial Assistance

Date: _____

1. Patient Information:

Last Name	First Name	Social Security Number
Street Address		Date of Birth
City	State	Zip Code
Telephone Number		
Medical Record Number (if available)		
Residency Status: <input type="checkbox"/> Citizen of the US		<input type="checkbox"/> Visitor in the US
<input type="checkbox"/> Undocumented Resident, Specify Place of Birth		<input type="checkbox"/> Visa

2. Family Information: List your spouse and/or any dependent children living in your household (listed on your tax return). If more space is necessary, please attach a separate document.

Name of dependent	Relationship to applicant	Date of Birth	Age

3. Income Information:

Source of Income	Patient/Responsible Party Enter Amount Per Month	Spouse or Partner Enter Amount Per Month
Gross Wages/Earnings(Before Taxes)		
Supported by Other Individual		
Child Support/Alimony Received		
Disability Benefits		
Pension Benefits		
Self Employment, Business, Rental Income Received		
SocialSecurity/SSI Benefits		
Unemployment Benefits		
Workers Compensation		
Other Income (Interest, Stocks, Pending Settlements, Assets, etc.)		
Total Income		

4. Expense Information:

Expenses	Monthly Payment
Mortgage/Rent	
Auto Loan/Lease	
Medical Bills	
Utilities	
Credit Card/Other	
Total Expense	

5. Additional Information:

- Attach Proof of denial for Medical Assistance or status of current Medicaid application
- Attach Proof of household Income (last 3 pay stubs)
- Attach a copy of 3 most recent bank statements
- Attach a copy of the 2 most recent tax returns

Are you a veteran? Y N

Are you disabled? Y N

Do you have medical insurance? Y N _____

By signing below, I certify that everything I have stated on this application and any attachment is true. I understand that any incorrect, incomplete or false information on this form could result in rejection of my application for financial assistance. I acknowledge that I understand that the information which I submit as part of this application is subject to disclosure to federal and/or state agencies and I give my permission for Gaylord Specialty Healthcare to share this information with others to process this application and that more information may be requested before my eligibility can be determined. All information will remain confidential under HIPAA federal regulations.

Signature of Applicant or person acting on behalf of Applicant

Date

Print Name of Applicant

Signature of Witness

Date

Print Name of Witness