First Care HEALTH CENTER

Please complete and return by _____

FINANCIAL ASSISTANCE APPLICATION

Date:_____ Account Number(s): _____

Responsible Party Name:_____

Social Security #:_____ Date of Birth:_____

Street of Box #:_____Apt. #:_____

City:_____ State:_____ Zip Code: _____ Years There: _____

Home Phone #:_____ Work #: _____ Cell #:_____

Employment:_____ Job Title:_____

Address:_____Phone #: _____

City:_____ State:_____ Zip Code: _____ Years Employed: _____

Name and age of Dependent(s) other than spouse: _____

_____

Spouse/Significant Other:_____Date of Birth:_____Social Security #: _____

Employment:_____Job Title: _____

Address:_____Phone #: _____

City:_____ State:_____ Zip Code: _____ Years Employed: _____

FAMILY INCOME

Self **(Monthly Net)**: $ _____

Spouse/Significant Other: $ _____

(Monthly Net)

Alimony/Child Support: $ _____

Income from Rental Property: $ _____

Other: $ _____

Total Monthly Income: $ _____

By signing this agreement, I am promising to cooperate with First Care Health Center and provide adequate information in a timely manner to resolve my bill.

Signature of applicant _____ Date _____

Signature of co-applicant _____ Date _____

First Care
HEALTH CENTER

Please complete and return by _____