

## 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: \_\_\_\_\_

Are you or your spouse offered health insurance through an employer that you elect not to purchase? Yes  No

Do you have a roommate who shares the expenses? Yes  No

Are you seeking assistance because of a work-related accident or injury? Yes  No

Are you seeking assistance because of a car accident? Yes  No

Are you a student? Yes  No  If yes, are you full time? \_\_\_\_\_ part time? \_\_\_\_\_

Have you applied for any of the following:  Medicaid  Social  Security Disability  VA  Medicare  Migrant Health  
Date(s) applied: \_\_\_\_\_

### FAMILY INCOME

Self (Monthly Net): \$ \_\_\_\_\_

Spouse/Significant Other: \$ \_\_\_\_\_

**(Monthly Net)**

Alimony/Child Support: \$ \_\_\_\_\_

Income from Rental Property: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

**Total Monthly Income:** \$ \_\_\_\_\_