



## **FINANCIAL ASSISTANCE APPLICATION\*\***

If you wish to apply, please complete and return this form to the hospital. The form must be signed by the patient or the person responsible for the patient's claim.

### **REQUIREMENTS FOR APPLICATION:**

1. COPY OF PREVIOUS YEAR'S TAX RETURN
2. COPY OF CURRENT PAY STUBS/SOCIAL SECURITY/DISABILITY STATEMENT
3. NEED TO APPLY FOR MEDICAID AT YOUR COUNTY'S **FIA** DEPARTMENT. IF YOU ALREADY APPLIED, PLEASE ATTACH DENIAL. (If you have been approved for Medicaid with a spend down and/or deductible amount, you will not be eligible for this program.)
4. INCLUDE HOUSEHOLD INCOME (LIST YOURSELF AND ALL OTHER PERSONS WHO LIVE IN THE HOME.
5. IF YOU HAVE NO REGULAR, VERIFIABLE INCOME, PLEASE EXPLAIN HOW YOU SUPPORT YOURSELF AND/OR FAMILY.
6. DO YOU HAVE A HEALTH REMBURSEMENT ARRANGEMENT ACCOUNTS? IF YES, PLEASE INDICATE CURRENT BALANCE.

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Guarantor Information (Patient or person responsible for the patient's bill)

Guarantor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Guarantor Employer: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_ (Please list names and ages on the line below)

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**WE ALSO RESERVE THE RIGHT TO RUN A CREDIT CHECK ON ALL APPLICANTS REQUESTING FINANCIAL ASSISTANCE.**

Patient /Responsible party Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Witness: \_\_\_\_\_

(If patient/responsible party is unable to sign or complete the application, than please print the patient's name in the signature field and that person should sign as Witness.)

\*\* AGH FINANCIAL ASSISTANCE IS **NOT** FOR NON-MEDICALLY NECESSARAY SERVICES\*\*

**THE APPLICATION WILL BE DENIED, IF WE DO NOT RECEIVE ALL THE REQUIRED INFORMATION.**