

# Financial Assistance Application

**Please include applicable copies of your most recent federal income tax return, last 60 days of paystubs, social security benefit letter and/or unemployment benefit letter with this application.**

Name	Date of Birth	Home Phone	
Address	City	State	Zip

**Other Family Members (spouse or dependents)**

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

**Insurance Information**

Do you have insurance to cover medical expenses?     Yes     No

Primary Insurance		Secondary Insurance	
Name of Insurance Company		Name of Insurance Company	
Effective Date	Group Number	Effective Date	Group Number
Policy Number		Policy Number	

**Employment Status**

<b>Applicant</b> (check all that apply) <input type="checkbox"/> Employed <input type="checkbox"/> Unemployment <input type="checkbox"/> Retired-Social Security <input type="checkbox"/> Retired-Pension <input type="checkbox"/> Income Assistance <input type="checkbox"/> No Income	<b>Other household members</b> (check all that apply) <input type="checkbox"/> Employed <input type="checkbox"/> Unemployment <input type="checkbox"/> Retired-Social Security <input type="checkbox"/> Retired-Pension <input type="checkbox"/> Income Assistance <input type="checkbox"/> No Income
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**Income information for household members**

Applicant		Other household members	
Type	Annual, Wage & Hrs./Weekly	Type	Annual, Wage & Hrs./Weekly
Wages		Wages	
Unemployment		Unemployment	
Social Security		Social Security	
Pension		Pension	
Income Assistance		Income Assistance	
Alimony		Alimony	
Child Support		Child Support	

**Read and sign – Signature and date are required to process your application**

I certify that the above information is true and correct. I understand that the information I have provided is subject to verification by Amery Hospital & Clinic, for review by federal and state agencies, and for other programs or related purposes. I also understand that my application and eligibility for financial assistance may be subject to the specific guidelines of the location from which I received my care.

Signature	Date
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