



## FINANCIAL ASSISTANCE FORM

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Responsible Party (if different)

\_\_\_\_\_  
Address

City

\_\_\_\_\_  
Address (if different)

City

\_\_\_\_\_  
Phone No: Home/Cell

\_\_\_\_\_  
# Dependents (Self,Spouse,Children)

<b>SOURCE OF INCOME</b>	<b>MONTH</b>	<b>ANNUAL</b>	<b>EXPENSES</b>	<b>MONTH</b>	<b>ANNUAL</b>
_____ Income - salary, social security, other	\$ _____	\$ _____	Rent or House payment	\$ _____	\$ _____
_____ Second income, spouse income, etc	_____	_____	Property Taxes	_____	_____
_____ Other Income - Investments,rentals, etc	_____	_____	House Insurance	_____	_____
Other:	_____	_____	Utilities (Gas,Electric water & sewer)	_____	_____
	_____	_____	Phones	_____	_____
	_____	_____	Medical/Drug	_____	_____
	_____	_____	Vehicle payments	_____	_____
	_____	_____	Food	_____	_____
	_____	_____	Clothing	_____	_____
	_____	_____	Credit Card	_____	_____
	_____	_____	Other	_____	_____
Total	\$ _____	\$ _____		\$ _____	\$ _____

**ASSETS**

_____ Bank name, account number	\$ _____
_____ Bank name, account number	_____
_____ Other - CDs, stocks, mutual funds	_____
_____ Residence - value	_____
_____ Vehicles - value	_____
_____ Other (Do not list IRA or 401(k) assets)	_____
<b>TOTAL</b>	<b>\$ _____</b>

**LIABILITIES**

CMH Hospital Bills	\$ _____
CMH Physicians	_____
Other healthcare debts	_____
Mortgage	_____
Vehicle Loans	_____
Credit Card debt	_____
Other debts: _____	_____
_____	_____
<b>TOTAL</b>	<b>\$ _____</b>

**SIGNATURE**

I agree that the above is true and accurate to the best of my knowledge and that I can provide additional documentation, if requested.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date