DOSHER Memorial Hospital

Financial Assistance Application

Patient Name: _____ Account #: _____

Patient Address: _____

Phone #: _____ Assistance Requested by: _____
Relationship to Patient _____

List every member of the patient's household, including patient, as listed on the tax return. Use additional sheets if necessary.

NAME	AGE	RELATIONSHIP	GROSS MONTHLY INCOME	SOURCE OF INCOME

PLEASE COMPLETE THE FOLLOWING SECTION ON YOUR ASSETS, LIABILITIES, INCOME AND EXPENSES:

Do you own or rent your home? __Own __ Rent Monthly rent/mortgage amount: $ _____

Do you own or lease your car? __ Own __Lease Monthly car payment amount: $ _____

How much is your monthly living expense? __Less than $500 __Between $500 and $1,000

__ Between $1,000 and $2,000 __ More than $2,000

Total family income for the last three (3) months $ _____
Checking Account Balance $ _____ Savings Account Balance $ _____
Non-Retirement Investment $ _____ Retirement Savings Balance $ _____

PLEASE CHECK IF YOU RECEIVE OR HAVE ANY OF THE FOLLOWING ADDITIONAL RESOURCES:

__Commercial Insurance __ Veteran's __ Champus/Tricare __ Medicare __ Medicaid __ SNAP __ Food Stamps

__TANF __ COBRA _ Other, please specify: _____

Was this service due to an accident in which you may have a claim or be represented by an attorney?

If so, what is the attorney's name and contact information? _____

I certify that the above information is true and correct. I authorize J. Arthur Dosher to verify this information with employers and other agencies. I also understand that this information is subject to review by Federal and/ or State Agencies. I also understand that I am expected to make application to any other help, which may be available to me.

_____ _____
Signature Date Requested

Supporting Documentation for Income Verification such as: Previous Year Tax Return/ Copy of 3 most recent pay checks/ Written verification from employer on salary/ Social Security Benefits Letter/ 2 Bank Statements/ Letter of Support/ No Income Letter
** (**Not all apply**)