

**FINANCIAL ASSISTANCE APPLICATION**



Patient Name: \_\_\_\_\_ Account# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security# \_\_\_\_\_

Responsible Party: \_\_\_\_\_

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

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ How Long At This Address: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Number of Dependents: \_\_\_\_\_

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

Make/ Model of Car: \_\_\_\_\_ Year: \_\_\_\_\_

Make/ Model of Car: \_\_\_\_\_ Year: \_\_\_\_\_

Home: \_\_\_\_\_ Own \_\_\_\_\_ Rent \_\_\_\_\_ How Long \_\_\_\_\_

<u>Income Per Month</u>		<u>Expenses Per Month</u>	
Patient Net	_____	Loans	_____
Resp Party Net	_____	Mortgage/ rent	_____
Spouse Net	_____	Food	_____
Rental Property	_____	Car Payment	_____
Alimony	_____	Utilities	_____
Child Support	_____	Gas	_____
VA	_____	Water	_____
Social Security	_____	Phone	_____
Retirement	_____	Cable/ Sat	_____
Dividentds/ Interest	_____	Credit Cards	_____
Unemployment	_____	Child Care	_____
Total Income	_____	School/ Tuition	_____
	Income _____	Insurance (Med/ Car)	_____
	Expenses _____	Child Support/ Alimony	_____
Avail Cash Per Mo.	_____	Other	_____
		Total Expenses	_____

Banking

Checking \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Bank: \_\_\_\_\_  
 Savings \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Bank: \_\_\_\_\_

I understand that the information submitted is subject to verification by NEMC~ Physician Network and certify that the above information is true and correct to the best of my knowledge.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_