LORETTO HOSPITAL

PATIENT ACCOUNT NUMBER ____________________

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

Last Name	First	MI	Age	Social Security #	Dependents
Street	City	State	Zip Code	Home Phone	
Employer	Address			Cell Phone	
Address of Employer			Position	Work Phone	

SPOUSE/PARENT INFORMATION (IF MINOR)

Last Name	First	MI	Age	Social Security #	Dependents
Street	City	State	Zip Code	Home Phone	
Employer	Address			Cell Phone	
Address of Employer			Position	Work Phone	
Relationship to Patient					

INCOME INFORMATION

List all income, including employment income, spouse's income, rental income, Social Security, unemployment compensation, worker's compensation, alimony, child support, veteran's payments, insurance or annuity income, dividends, etc. Attach an additional sheet if more lines are needed. Provide copies (last 2-3 months).

DESCRIPTION OF INCOME	WEEKLY OR MONTHLY	PAID TO	GROSS AMOUNT

MEDICAL EXPENSES

List outstanding medical bills, including bills from your physician, anesthesiologist, dentist, and for prescriptions, diagnostic testing, hospital services, etc. Attach an additional sheet if more lines are needed.

PERSONAL FINANCIAL STATEMENT (INCLUDE SPOUSE'S INFORMATION)

ASSETS (What you own with cash value):		Monthly expenses	
Savings (Name $ Acct #)			
______________________	$_______	Real Estate Loan/ Mortgage	$ ____________
Checking (Name & Acct #)		Rent	$ ____________
______________________	$_______	Auto Loans	$ ____________
Retirement Plan	$_______	Credit Cards	$ ____________
Real Estate (Market Value)	$_______	Other	$ ____________
Vehicle (s)	$_______	Utilities	$ ____________
Other Assets	$ _______		$ ____________
		Food	$ ____________
		Child Care	$ ____________
		Student Loan	$ ____________

PLEASE PROVIDE ANY INFORMATION THAT MAY ASSIST US IN ASSESSING YOUR FINANCIAL SITUATION.

I/We certify that the above information is true and complete to the best of my/our knowledge.

Applicant (s) authorize Loretto Hospital to check my/our employment and credit history.

Patient's Signature ______________________________ Date __________

Responsible Party's Signature ____________________________ Date