FINANCIAL ASSISTANCE APPLICATION

I hereby request that Electra Hospital District make a determination of my eligibility for financial assistance. I understand that all third-party liabilities are to be turned in and assigned to the hospital for all possible recovery of this bill. I also understand that I am to make every effort to obtain any third-party coverage such as SSI or PIP and am obligated to report any information as received.

I understand that proof of income must be provided before my application can be processed in the form of a copy of check, check stub, or written verification from my employer of gross monthly income and period of time employed.

NOTE: Your application will not be processed unless all the requested information is attached, and the form is completed in full. If we do not receive your proof of income, your request for financial assistance WILL BE DENIED.

PART I – PATIENT INFORMATION

Patient Name: ____
First Middle Last

Address: ____
Street City State Zip

Home Phone: ___________ Cell Phone: _____________ Work Phone: _____________

Email: ____

SSN: ______________________ DOB: ______________________

Employer: ______________________ Occupation: _______________

Guarantor: ______________________ Relationship to Patient: ______________

Employer: ______________________ SSN: ______________________

Preferred Pharmacy (check one):

☐ Goldsmith's

☐ Iowa Park Pharmacy

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PART II – INCOME
PLEASE ATTACH PROOF OF ANYTHING LISTED BELOW

	MONTHLY	YEARLY
Wages Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly	______	______
Farm or Self Employment	______	______
Public Assistance	______	______
Social Security	______	______
Unemployment Compensation	______	______
Workers' Compensation	______	______
Strike Benefits	______	______
Alimony	______	______
Child Support	______	______
Veterans Assistance	______	______
Pension	______	______
Dividends, Interest or Rental Income	______	______
TOTAL INCOME	______	______

PART III – HOUSEHOLD FAMILY MEMBERS (everyone living in the home that is related by birth, marriage or adoption)

NAME	DOB	RELATIONSHIP	INCOME	SOURCE OF INCOME

I affirm that the information on this application is true and correct to the best of my knowledge. I agree to abide by the terms and conditions of the financial assistance category for which I qualify.

Signature of Applicant: ______________________________ Date: ____________

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