Financial Assistance Application

Name:_____ Account Number(s):_____

Address:_____ Length at address:_____

City:_____ State:_____ Zip:_____ Phone:_____

List all household members by legal name, including yourself

Name (Last, First & Middle Initial)	Date of Birth	Age	Relation to Guarantor	Occupation	Social Security Number	Gross Annual Income
					Total	

Sources of Gross Household Income:

Employer	
Social Security	
Self-Employment Income	
Interest	
Workers Compensation	
Unemployment Compensation	
Alimony	
Rental Income	
Pension / Retirement Income	
Investment Income	
Other Income or Support	
Total	

Vehicles:

1	Brand	
	Model	
	Year	
	Market Value	
2	Brand	
	Model	
	Year	
	Market Value	
3	Brand	
	Model	
	Year	
	Market Value	

Savings, Checking and Investment Accounts:

Type of Account	Institution Name	Balance
☐ Savings ☐ Checking ☐ Money Market ☐ CD's		
☐ Savings ☐ Checking ☐ Money Market ☐ CD's		
☐ Savings ☐ Checking ☐ Money Market ☐ CD's		
☐ Stocks ☐ Bonds		
☐ Stocks ☐ Bonds		
☐ Stocks ☐ Bonds		
IRAs and 401k / 403b employee sponsored plans		
Total		

Real Estate

Type of Real Estate	Market Value	Mortgage Payment	Outstanding Balance
☐ Primary Residence ☐ Secondary Residence ☐ Rental Property			
☐ Primary Residence ☐ Secondary Residence ☐ Rental Property			
☐ Primary Residence ☐ Secondary Residence ☐ Rental Property			
☐ Primary Residence ☐ Secondary Residence ☐ Rental Property			
☐ Primary Residence ☐ Secondary Residence ☐ Rental Property			

Monthly Payments & Living Expenses

	Total monthly payment
Medical, including health insurance and monthly medication	
Housing and utilities, including rent, power, gas, water, property tax and/or mortgage	
Transportation, including car payments, car insurance and/or monthly transportation costs	
Other living expenses, including day care, child support, tuition and/or alimony	

Do you any outstanding medical bills, not including the bill for which you are currently applying for financial assistance?

☐ Yes ☐ No If yes, what is the total amount due: _____

Do you have Medical Insurance? ☐ Yes ☐ No

Company Name: _____ Policy Number:_____ Group Number/Name:_____

Do you have Auto Insurance? ☐ Yes ☐ No

Company Name: _____ Policy Number:_____ Group Number/Name:_____

Do you have Individual or Supplemental Insurance? ☐ Yes ☐ No

Company Name: _____ Policy Number:_____ Group Number/Name:_____

Do you have Medicare or Medicaid? ☐ Yes ☐ No Medicare Num: _____ Medicaid Num:_____

Statement

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release to Piedmont Healthcare proof of my income. I understand that if any information I have given proves to be untrue, Piedmont Healthcare will re-evaluate my financial status and take whatever action becomes appropriate.

_____ _____ _____ _____

Signature of Applicant Date Signature of Witness Date