

Name of Each Household Member:	1.	2.	3.
Monthly Income From:			
Employment	\$	\$	\$
Self Employment	\$	\$	\$
Investment Accounts	\$	\$	\$
Real Estate Rentals	\$	\$	\$
Unemployment (since / /)	\$	\$	\$
Retirement:	\$	\$	\$
(Soc. Sec., Pension, Annuity)			
Alimony/Child Support	\$	\$	\$
Public Assistance, Food Stamps	\$	\$	\$
Other	\$	\$	\$
TOTAL GROSS INCOME HOUSEHOLD	\$	\$	\$
Savings and Investments:			
Checking Acct Balances	\$	\$	\$
Savings & CD Account Balances	\$	\$	\$
IRAs, 403B, 401K:	\$	\$	\$
Specify _____			
Other Savings and Investments:	\$	\$	\$
Specify _____			
Other:			
Value of Home	\$	\$	\$
Value of Automobile	\$	\$	\$
Year, Make, Model			
Value of Recreation Vehicle:	\$	\$	\$
(boat, jet ski, ATV, snowmobile, etc.)			
Year, Make Model			

16. HOUSEHOLD EXPENSES

MORTGAGE/RENT	Monthly	UTILITIES	Monthly	NECESSITIES	Monthly
Home	\$	Oil/Gas	\$	Groceries	\$
Apartment	\$	Wood	\$	Child Support	\$
Lot/Land	\$	Other Heat	\$	OTHER	\$
Property Taxes	\$	Water & Sewer	\$	Gas/Vehicle #1	\$
MEDICAL EXPENSES		Electricity	\$	Gas/Vehicle #2	\$
Physicians/Providers	\$	PERSONAL VEHICLES		Telephone	\$
	\$	Vehicle #1	\$	Cable	\$
	\$	Vehicle #2	\$	Child Care	\$
Pharmaceutical	\$	INSURANCES		Incidentals	\$
LRGH	\$	Medical/Health	\$	CHARGE CARDS	
Other Medical:	\$	Vehicle #1	\$	1.	\$
	\$	Vehicle #2	\$	2.	\$
	\$	Homeowners/Rental	\$	3.	\$

17. ASSIGNMENT OF RIGHTS *Read Carefully*

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care provider from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment. If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof application.

Signature _____ Date _____

Signature _____ Date _____