HOLY SPIRIT HOSPITAL
FINANCIAL ASSISTANCE APPLICATION FOR ELIGIBILITY DETERMINATION

PATIENT NAME: ______________________ TELEPHONE #: _______________

ADDRESS: ____
(Street) (City) (State) (Zip Code)

NUMBER OF PERSONS IN FAMILY: _______

1) NAME: _______________________________ AGE: __________
2) NAME: _______________________________ AGE: __________
3) NAME: _______________________________ AGE: __________
4) NAME: _______________________________ AGE: __________
5) NAME: _______________________________ AGE: __________

INCOME:

FAMILY INCOME LAST TWELVE (12) MONTHS:___________________

FAMILY INCOME LAST THREE (3) MONTHS:__________X4=__________

<u>TOTAL INCOME FOR LAST MONTH</u>

WAGES:	____________	**SELF EMPLOY:**	__________
PUBLIC ASSISTANCE:	____________	**FARM:**	__________
SOCIAL SECURITY:	____________	**STRIKE BENFITS:**	__________
UNEMPLOYMENT/ WORKMEN'S COMP:	____________	**ALIMONY:**	__________
CHILD SUPPORT:	____________	**PENSIONS:**	__________
MILITARY FAMILY ALLOTMENT:	____________	**DIVIDENDS/ INTEREST:**	__________
MONEY FROM RENT:	_____________	**OTHER:**	__________
		TOTAL:	__________

__________________ **If you are seeking financial assistance for services already rendered by Holy Spirit Hospital, list dates of service:**
____

__________________ **If you are seeking an eligibility determination for services not yet received, check type of service sought:**

_______ Emergency Room **_______ Outpatient Clinic**
_______ Medical/Surgical **_______ Inpatient**
_______ Other

I understand that the information I submit can be verified by Holy Spirit Hospital. I certify the above information to be correct for financial assistance determination.

______________________ **____________________________________**
DATE **SIGNATURE OF PERSON MAKING REQUEST**