			plication for Fina	IICIAI ASSIS	tarice	
Patient Name		cial Security #	Medical Record #		Received	Date App Returned
	Address		Guarantor (ie. Spo	use, Significant Ot	her, Parent, etc)	Relationship
Street:		Name				
			Street			
City, ST, Zip			City, ST, Zip			
Phone #			Phone #			
List all members of the h	nousehold including	age & relationship (ι	use a separate sheet if neede	d)		
Verification of inco	me on all amounts l	listed helow is requi	Employment red. Please provide docume	antation such as	:W/2 Payetuh or	Letter from Employer
Patient's Employer	ine on an amounts	iisteu below is requi	Guarantor's Employer		wz, raystub, or	Letter from Employer
Address			Address			
Phone #	Monthly Gross Inc	ome	Phone #		Monthly Gross	Income
	Other Monthly	v Income (in set chile	d Support, Workman's Comp, Unen	unlayment Bansian	Pont Alimony etc)	
Other Monthly Income	Other Worth	y Income (ie. ssi, chiid	Other Monthly Incom		Kent, Allmony, etc)	
Туре			Туре			
If you do not have mont	hly income, please e	explain how you take	e care of your monthly expen	ses		
If you do not have mont	hly income, please ε	explain how you take	e care of your monthly expen	ses		
			e care of your monthly expen		No Date Apr	olied:
Do you have health insu	rance? Yes	explain how you take	e care of your monthly expen		<b>No</b> Date App	
If you do not have mont  Do you have health insu  If Yes, Name of Insuranc	rance? Yes		Health Insurance Have you applied for			
Do you have health insu	rance? <b>Yes</b> e	No	Health Insurance Have you applied for Date Applied:	Medicaid? <b>Yes</b>	If Denied, Date	
Do you have health insu	rance? <b>Yes</b> e	<b>No</b> opy of health insurar	Health Insurance Have you applied for I Date Applied: Reason for Denial: nce or Medicaid corresponda	Medicaid? <b>Yes</b>	If Denied, Date	
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Do you have health insu If Yes, Name of Insuranc Primar Seconda Vehicle #1 Make_	rance? Yes e  Attach co  Str  Health Savings/	No  Checking Back Savings Back Certificates of Docks/Bonds/Mutual Flexible Spending Acceptable Spending Ac	Health Insurance Have you applied for I Date Applied: Reason for Denial: nce or Medicaid corresponda Financial Information Banking & Investment slance \$ eposit \$ Funds \$ count \$  Assets & Liabilities Value	Medicaid? Yes  nce of approval	or denial	

Other Assets (Including Artwork, Jewelry	у;				
Recreational Vehicles, Campers, etc)		Value		Balance Due	
<del></del>		\$		<u> </u>	
		\$		<u> </u>	
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		<u>\$</u> \$			
		\$		<u>,                                      </u>	
6 1/5				<del></del>	
Self-Employed Include:  Trade Tools/Equipment	\$		¢		
Business Real Estate	\$		\$		
Business Vehicles	\$		\$		
	<del>.</del>	<del></del> ,	<del>. '</del>		
Other Liabilities					
Payment To					
Payment To					
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I certify that the above information is a ssistance which may be available for pay btain such assistance and will assign or pa is to be used to ascertain my ability to p	ment of my cha ay to the facility ay for the servio	rges (Medicaid, Insurance, e y the amount recovered for s ces provided by Decatur Hea	tc.) and I will tak such charges. I u lth. I hereby gra	e any action reasonably necessal nderstand that the information g	
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