PHELPS MEMORIAL HEALTH CENTER
Financial Assistance Application

HOUSEHOLD INFORMATION		
Application Date:		
Responsible Party Name:		Date of Birth:
Home Phone:	Work Phone:	SS# (Optional):
Home Address:		
Employer Name:	Employer Address:	
Position/Title:	Length of Employment (Yrs/Mo):	
Spouse/Significant Other Name:		Date of Birth:
Home Phone:	Work Phone:	SS# (Optional):
Employer Name:	Employer Address:	
Position/Title:	Length of Employment (Yrs/Mo):	

Dependent Name	Age	Relationship to Responsible Party	Employer (if any)

Health Insurance Carrier:	Have you applied for Medicaid (Y/N):
Do you have supplemental insurance (AFLAC, etc.) (Y/N):	If Yes, Name of coverage:

HOUSEHOLD MONTHLY INCOME			
	Responsible Party	Spouse/Other Household members	Total
Gross Salary/Wages	$	$	$
Farm/Self Employment			
Pensions			
Investment Interest/Dividend			
Rental Income			
Work Comp			
Social Security/Disability			
Military			
Alimony/Child Support			
Unemployment			
Other:			
TOTAL GROSS MONTHLY INCOME			**$**

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Please include the following additional required information listed below with your completed application:

- **Federal and State Tax returns for the most recently completed tax year**
- **Proof of current year income for the most recent 3 months from ALL sources of earnings for each person in the household (pay stubs, SSI/SSA/Disability statements, bank statements, etc.)**

Phelps Memorial Health Center reserves the right to request or access additional information as needed to validate the information listed in this application.

I hereby certify that all of the information contained herein is accurate and true to the best of my knowledge. If any of the information is deemed to be untrue or falsified, the application will be denied and I will be held liable for all charges related to services provided.

_____ _____

Signature Date

_____ _____

Spouse/Significant Other Date