

# Beaumont

## FINANCIAL ASSISTANCE FORM

**Instructions: Complete application, return within 10 days, and attach copies of:**

- Tax returns and supporting schedules
- Social Security benefits (if applicable)
- On separate page describe your need for financial assistance
- Pay stubs (3 most recent)
- Bank statements (most recent 3 months/all accounts)
- W-2's or unemployment statements

| Patient Information                                       |                            |                   |
|---|----------------------------|-------------------|
| Patient Name  | Date of Birth (MM/DD/YYYY) |                   |
| Address   |                            |                   |
| Social Security #   | Telephone (    )           |                   |
| Responsible Party Information                             |                            |                   |
| Name & Address  |                            |                   |
| Social Security #   | Telephone (    )           |                   |
| Employer Name & Address                                   |                            |                   |
| Telephone (    )  | Occupation                 |                   |
| Employment Length   | Monthly Salary             | No. of Dependents |
| Driver's License Number                                   |                            |                   |
| Spouse Information  |                            |                   |
| Name & Address  |                            |                   |
| Social Security #   | Telephone (    )           |                   |
| Employer Name & Address                                   |                            |                   |
| Telephone (    )  | Occupation                 |                   |
| Employment Length   | Monthly Salary             | No. of Dependents |
| Family Group Living in Home                               |                            |                   |
| DEPENDENTS (if more than 5 dependents, use separate page) |                            |                   |
| Name  | Relationship               | Age               |
| Name  | Relationship               | Age               |
| Name  | Relationship               | Age               |
| Name  | Relationship               | Age               |
| Name  | Relationship               | Age               |

| Health Insurance Information              |                 |  |                  |                   |
|---|-----------------|--|------------------|-------------------|
| Insurance Company                         | Address         | Subscriber                               | Eligibility Date | Policy & Group #s |
|   |                 |  |                  |                   |
|   |                 |  |                  |                   |
| Assets / Expenses                         |                 |  |                  |                   |
| RESIDENCE                                 | Monthly Payment | Value                                    | Unpaid Balance   |                   |
| Monthly Mortgage / Rent Payment           | \$              | \$                                       | \$               |                   |
| Second Residence / Vacation Home          | \$              | \$                                       | \$               |                   |
| AUTO                                      | Year / Make     | Monthly Payment                          | Unpaid Balance   |                   |
| First Auto                                |                 | \$                                       | \$               |                   |
| Second Auto                               |                 | \$                                       | \$               |                   |
| Additional Income Information             |                 |  |                  |                   |
| TOTAL HOUSEHOLD INCOME                    | \$              |  |                  |                   |
| Child Support                             | \$              | Alimony                                  | \$               |                   |
| Worker's Compensation                     | \$              | Unemployment                             | \$               |                   |
| Social Security / Disability              | \$              | Unemployment Date / Length               |                  |                   |
| Rental                                    | \$              | Land Contract                            | \$               |                   |
| Dividend / Interest                       | \$              | Trust Fund                               | \$               |                   |
| Public Assistance                         | \$              | Retirement / Pension                     | \$               |                   |
| <b>BANK</b>                               |                 | Location                                 |                  |                   |
| <input type="checkbox"/> Checking Balance | \$              | <input type="checkbox"/> Savings Balance | \$               |                   |

I understand this form must be completed in full and have all required documents attached when returned by me so Beaumont can determine if I qualify for financial assistance. If it is not complete, I will receive a written notice that describes the additional information and/or documents required. I have provided true and accurate information, and I agree that Beaumont may investigate this information and obtain my credit history/report.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

|                       |
|-----------------------|
| For Internal Use Only |
| Patient Hospital ID   |