

QHS Financial Assistance Application

TODAY'S DATE ____/____/____	TODAY'S TIME :	CURRENT PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	REFERRED BY:
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INFORMATION ABOUT YOU

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH ____/____/____
HOME ADDRESS		CITY	STATE ZIP CODE
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNK	HOME PHONE () -	SOCIAL SECURITY NO.
US CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	PERMANENT RESIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	COMMENT	

EMPLOYMENT INFORMATION

EMPLOYER NAME	WORK PHONE () -	OCCUPATION
EMPLOYER ADDRESS	CITY	STATE ZIP CODE

HOUSEHOLD MEMBERS

NAME	AGE	RELATIONSHIP

OTHER ASSISTANCE INFORMATION

HAVE YOU APPLIED FOR MEDICAL ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT WAS THE DATE YOU APPLIED? ____/____/____	IF YES, WHAT WAS THE DETERMINATION? <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED	COMMENT
DO YOU RECEIVE ANY TYPE OF STATE OR COUNT ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT TYPE?	

UNDERINSURED INFORMATION

ARE YOU REQUESTING ASSISTANCE DUE TO INSUFFICIENT INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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INSURANCE INFORMATION

INSURANCE CARRIER 1		INSURANCE CARRIER 2	
INSURANCE NAME		INSURANCE NAME	
ID #	GROUP#	ID #	GROUP#
SUBSCRIBER NAME		SUBSCRIBER NAME	
INSURANCE PHONE # () -	EXTENSION	INSURANCE PHONE # () -	EXTENSION

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List the amount of your monthly income and assets from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support for the person providing your housing and meals.

I. FAMILY INCOME	Monthly Amount	II. LIQUID ASSETS	Current Balance
<input type="checkbox"/> Employment	\$	<input type="checkbox"/> Checking account	\$
<input type="checkbox"/> Retirement/pension benefits	\$	<input type="checkbox"/> Savings account	\$
<input type="checkbox"/> Social security benefits	\$	<input type="checkbox"/> Stocks	\$
<input type="checkbox"/> Public assistance benefits	\$	<input type="checkbox"/> Bonds	\$
<input type="checkbox"/> Unemployment benefits	\$	<input type="checkbox"/> Certificates of Deposit (CD)	\$
<input type="checkbox"/> Veterans benefits	\$	<input type="checkbox"/> Money Market Funds	\$
<input type="checkbox"/> Alimony	\$	<input type="checkbox"/> Other accounts	\$
<input type="checkbox"/> Rental property income	\$	<input type="checkbox"/> Other accounts	\$
<input type="checkbox"/> Strike benefits	\$	<input type="checkbox"/> Other accounts	\$
<input type="checkbox"/> Military allotment	\$	<input type="checkbox"/> Other accounts	\$
<input type="checkbox"/> Farm or self employment	\$	<input type="checkbox"/> Other accounts	\$
<input type="checkbox"/> Other income source	\$	<input type="checkbox"/> Other accounts	\$
Total	\$	Total	\$

III. OTHER ASSETS			
List the amount of your monthly income from all sources. You may be required to supply proof of income, assets and expenses. If you have no income, provide a letter of support from the person providing your housing and meals.			
<input type="checkbox"/> Home		Loan Balance	Approximate Value
		\$	\$
<input type="checkbox"/> Automobile	Vehicle Make	Year	Approximate Value
			\$
<input type="checkbox"/> Additional vehicle	Vehicle Make	Year	Approximate Value
			\$
<input type="checkbox"/> Additional vehicle	Vehicle Make	Year	Approximate Value
			\$
<input type="checkbox"/> Other property	Type of Property		Approximate Value
			\$
Total			\$

IV. MONTHLY EXPENSES	Amount		Amount
<input type="checkbox"/> Rent	\$	<input type="checkbox"/> Health insurance	\$
<input type="checkbox"/> Mortgage	\$	<input type="checkbox"/> Health insurance (other)	\$
<input type="checkbox"/> Car payment	\$	<input type="checkbox"/> Other medical expenses	\$
<input type="checkbox"/> Car payment (other vehicle)	\$	<input type="checkbox"/> Medical expenses	\$
<input type="checkbox"/> Car payment (other vehicle)	\$	<input type="checkbox"/> Other medical expenses	\$
<input type="checkbox"/> Car insurance	\$	<input type="checkbox"/> Other medical expenses	\$
<input type="checkbox"/> Credit card (other)	\$	<input type="checkbox"/> Other medical expenses	\$
<input type="checkbox"/> Credit card (other)	\$	<input type="checkbox"/> Other expenses	\$
<input type="checkbox"/> Credit card (other)	\$	<input type="checkbox"/> Other expenses	\$
<input type="checkbox"/> Credit card (other)	\$	<input type="checkbox"/> Other expenses	\$
Total	\$	Total	\$

REGISTRAR COMMENT		
Do you have any other unpaid medical bills? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, for what service?	Service
Have you arranged for a monthly payment plan? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what is the monthly payment?	Monthly Payment
		\$

If you request that the hospital or its affiliates extend additional financial assistance, the hospital or affiliate may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital or affiliate of any changes to the information within ten days of the change.

Applicant Signature _____

Date _____

Relationship to Patient _____