Use ***BLACK*** *ink only*

Livingston Hospital

FINANCIAL ASSISTANCE APPLICATION

Please complete the application to the best of your ability and as fully as possible and return within ten working days. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application. Any questions, call 270-988-2299.

YOU MUST ALSO PROVIDE PROOF OF GROSS HOUSEHOLD INCOME. THIS MAY BE IN THE FORM OF:

1. **LAST FOUR (4) PAY STUBS**
2. **LAST YEAR'S FEDERAL (1040) TAX RETURN AND ANY ATTACHED SCHEDULES**
3. **SOCIAL SECURITY INCOME AWARD LETTER OR 1099 (NO BANK STATEMENTS**

PATIENT INFORMATION (PLEASE PRINT)

Patient Name	Birth Date	Age	Marital Status M S W D	Sex M F	Telephone No.
Street Address	City			State	Zip Code
Social Security Number	Occupation	Employer	How long?	FT ☐ PT ☐	How many hrs/wk?
Employer Address	City	State	Zip Code		Telephone No.

RESPONSIBLE PARTY'S INFORMATION

Email:

Name	Birth Date	Age	Marital Status M S W D	Sex M F	Telephone No.
Address	City			State	Zip Code
Social Security Number	Occupation	Employer	How long?	FT ☐ PT ☐	How many hrs/wk?
Employer Address	City	State	Zip Code		Telephone No.

RESPONSIBLE PARTY SPOUSE INFORMATION

Spouse's Name			Birth Date	Sex M F
Social Security Number	Occupation	Employer	How long?	FT ☐ PT ☐ How many hrs/wk?
Employer Address	City	State	Zip Code	Telephone No.

DEPENDENTS (Anyone living in household)

Name	Age	Relation	Name	Age	Relation
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Continued on other side

ASSETS

ASSETS	dollar amount:
Cash on Hand	
Savings Account	
Checking Account	
C.D.'s	
Securities	
Life Insurance	
Home Value	
Other Real Estate	
Other	
TOTAL	

Vehicle Information

	Make	Year	Value
1.			
2.			
3.			

GROSS MONTHLY INCOME (Need proof of Income)

Source	Amount
Applicant	
Applicant Spouse	
Social Security	
V.A. Pension	
Pension	
Unemployment	
Worker's Compensation	
Interest Income	
Dividend Income	
Child Support	
Alimony	
Income from Rental Property	
Food Stamps	
Other	
Other	
TOTAL	

FINANCIAL SETTLEMENTS

Source	Amount
Insurance	
Inheritance	
Other	
TOTAL	

Comments: ______________________________

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DEBTS

DEBTS		dollar amount:
Home Loan Balance		
Car Loan Balance		
Credit Card Balances:		
1.		
2.		
3.		
Other Debts:		
TOTAL		

MONTHLY PAYMENTS

Item		Amount
Mortgage (PITI)		
Rent		
Electric		
Gas		
Telephone / Cell Phone		
Water		
Cable		
Food		
Furniture		
Car Payment		
Clothing		
Day Care		
Child Support		
Alimony		
Credit Cards:		
1.		
2.		
3.		
Payments on Medical Bills:		
1.		
2.		
3.		
4.		
Insurance:		
Auto		
Property		
Medical		
Loan Payments:		
1.		
2.		
TOTAL		

I, (your name) ______________________________, do solemnly state that the information contained on this application is true and accurate to the best of my knowledge and belief. You are authorized to check my credit and employment history.

______________________________ **Date**

______________________________ **Signature of Patient**

Revised 3/16