

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 <input type="checkbox"/> PT <input type="checkbox"/>	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 <input type="checkbox"/> PT <input type="checkbox"/>	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 <input type="checkbox"/> PT <input type="checkbox"/>	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**

dollar amount:

Cash on Hand	_____	
Savings Account	_____	
Checking Account	_____	
C.D.'s	_____	
Securities	_____	
Life Insurance	_____	
Home Value	_____	
Other Real Estate	_____	
Other	_____	
<b>TOTAL</b>	_____	
<b>Vehicle Information</b>		
Make	Year	Value
1.		
2.		
3.		

**GROSS MONTHLY INCOME (Need proof of Income)**

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	_____
<b>TOTAL</b>	_____

**FINANCIAL SETTLEMENTS**

Insurance	_____
Inheritance	_____
Other	_____
<b>TOTAL</b>	_____

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DEBTS**

dollar amount:

Home Loan Balance	_____
Car Loan Balance	_____
Credit Card Balances:	
1.	_____
2.	_____
3.	_____
Other Debts:	
_____	_____
_____	_____
_____	_____
_____	_____
<b>TOTAL</b>	_____

**MONTHLY PAYMENTS**

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

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