



FINANCIAL ASSISTANCE APPLICATION**

If you wish to apply, please complete and return this form to the hospital. The form must be signed by the patient or the person responsible for the patient’s claim.

REQUIREMENTS FOR APPLICATION:

1. COPY OF PREVIOUS YEAR’S TAX RETURN
2. COPY OF CURRENT PAY STUBS/SOCIAL SECURITY/DISABILITY STATEMENT
3. NEED TO APPLY FOR MEDICAID AT YOUR COUNTY’S **FIA** DEPARTMENT. IF YOU ALREADY APPLIED, PLEASE ATTACH DENIAL.
4. INCLUDE HOUSEHOLD INCOME (LIST YOURSELF AND ALL OTHER PERSONS WHO LIVE IN THE HOME.
5. IF YOU HAVE NO REGULAR, VERIFIABLE INCOME, PLEASE EXPLAIN HOW YOU SUPPORT YOURSELF AND/OR FAMILY.
6. DO YOU HAVE A HEALTH REMBURSEMENT ARRANGEMENT ACCOUNTS? IF YES, PLEASE INDICATE CURRENT BALANCE.

Patient Name: _____

Patient Date of Birth: _____

Guarantor Information (Patient or person responsible for the patient’s bill)

Guarantor Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Guarantor Employer: _____

Spouse Employer: _____

Number of Dependents: _____ (Please list names and ages on the line below)

WE ALSO RESERVE THE RIGHT TO RUN A CREDIT CHECK ON ALL APPLICANTS REQUESTING FINANCIAL ASSISTANCE.

Patient /Responsible party Signature: _____ DATE: _____

Witness: _____

(If patient/responsible party is unable to sign or complete the application, than please print the patient’s name in the signature field and that person should sign as Witness.)

**** AGH FINANCIAL ASSISTANCE IS NOT FOR NON-MEDICALLY NECESSARAY SERVICES**
ELECTIVE SURGERY WILL NOT BE APPROVED FOR ASSISTANCE THRU THIS PROGRAM**

THE APPLICATION WILL BE DENIED, IF WE DO NOT RECEIVE ALL THE REQUIRED INFORMATION.