RIVER BEND HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Accounts: ___10__________________________

INFORMATION ABOUT YOU:

APPLICANT''S NAME (LAST, FIRST, MIDDLE) ______________________________
SOCIAL SECURITY NO. ______________________________
BIRTH DATE ______________________________

CURRENT ADDRESS

____
STREET, CITY, STATE, ZIP

TELEPHONE NUMBER____

NUMBER IN HOUSEHOLD: _________

MEMBERS OF HOUSEHOLD (names) ___________________________________ RELATIONSHIP ________SELF_______________
___________________________________ RELATIONSHIP ____________________________
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___________________________________ RELATIONSHIP ____________________________

MARITAL STATUS: MARRIED: YES / NO SEPARATED: YES / NO UNMARRIED: YES / NO

INFORMATION ABOUT YOUR INCOME:

YOU MUST PROVIDE US WITH A COMPLETE COPY OF YOUR MOST RECENT TAX RETURN AND A RECENT PAY STUB SHOWING YEAR-TO-DATE INCOME IN ORDER FOR THIS APPLICATION TO BE PROCESSED.

EMPLOYER'S NAME:_____________________________________ ADDRESS____

LENGTH OF CURRENT EMPLOYMENT:_______________________YEARS________________________MONTHS

PRESENT SALARY: PER WEEK$_______________PER MONTH_______________PER YEAR_______________

CHILD SUPPORT/ALIMONY RECEIVED: AMOUNT $_______________WKLY_______________ MTHLY_______________

OTHER INCOME: _____________ (monthly)

Is the patient covered by any insurance ? NO YES ____
(persons under age 26 may be covered by their parent's insurance) ◯ Applied for Medicaid: _______________

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Signatures: *I certify that everything I have stated in this application and on any attachment is correct. You may keep this application whether or not it is approved. By signing below, I authorize you to check employment history and to answer questions others may ask you about my credit record with you. I understand that I must update credit information at your request if my financial condition changes.*

____ ______________________________
APPLICANT SIGNATURE DATE

____ ______________________________
CO-APPLICANT SIGNATURE DATE

Approved for Financial Assistance: ______________________

Denied for Financial Assistance: _________________________ Denial Reason: ____________________________________

Qualified RBH Representative:_____________________Date________ RBH Administrator:_____________________Date________
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