

Instructions: Please complete application and sign. Any incomplete applications will be returned.

Patient information

Last name		First name		Birthdate		Social Security number	
Street		Apt number		City		State Zip Home phone	
Employer		Employer's address		Work phone		Cell phone	
City		State		Zip		Position	
Guarantor's primary bank		Address		City/State			

Parent/Spouse information (if patient is a minor)

Last name		First name		Birthdate		Social Security number	
Street		Apt number		City		State Zip Home phone	
Employer		Employer's address		Work phone		Cell phone	
City		State		Zip		Position	
Guarantor's primary bank		Address		City/State			

Income information

Please list all income below. Include spouse's income, rental income, Social Security, unemployment compensation, worker's compensation, verteran's payments, insurance or annuity income, dividends, etc. Attach an additional sheet if more lines are needed. Provide copies of last pay stub, or income records, and most recent fereal tax return with W-2s.

Income Received	Received from	Gross amount
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		

Expenses	Rent/mortgage:	Utilities:
	Medical expenses:	
	Number of dependents:	Please use back side to list members of family living in the household

Attach copies of any outstanding medical bills, utility bills or other expenses you would like considered in the determination. Please list any unusual circumstances that are not reflected in the income section that you would like us to consider on the back of this form, or on a seperate piece of paper such as a recent loss of job or income.

Support statement: If you reported \$0.00 income, please have this section completed by the person(s) helping you.
I am assisting the patient by providing room and board, but I am not responsible for payment of his/her medical bills.

Print name	Length of time providing room/board to patient
Signature	Relationship to patient

Patient/Guarantor statement:

I certify that the above information is true and complete to the best of my knowledge. Applicant(s) authorize St. Bernard Hospital and Healthcare Center to verify address, employment and credit history.

Patient/Guarantor Signature: _____ **Date:** _____

