Community Hospital of Bremen
OUR FAMILY CARING FOR YOURS

Financial Assistance Application

Answers for every question are required. If a question does not apply to you, please indicate N/A. Be sure to complete both pages.

Instructions: Complete application and attach the following for all family members:

- Tax Return (current)
- Social Security benefits (if applicable)
- Pay Stubs (most recent 3 months)
- Bank Statements (Most recent 3 months)
- W-2 or Unemployment Statements

Patient/Responsible Party

Name *(First, Middle, Last)*	**Social Security Number**	**Birth Date *(MM, DD, YY)***

Address	**City**	**State**	**Zip Code**

Phone	**Household Size (Patient, Spouse, and Dependents)**	**Marital Status**

Employment Status ☐ **Full Time** ☐ **Part Time** ☐ **Self Employed** ☐ **Unemployed**	**Unemployed Date (MM, DD, YY)**

Employer Name	**Employment Length**

Gross Employment Income	☐ **Hourly** ☐ **Weekly** ☐ **Bi-weekly**

If not employed, please select all applicable reasons why:

☐ **Health Problems** ☐ **Unable to find work** ☐ **Student** ☐ **Disabled**
☐ **Laid-off** ☐ **Not seeking employment** ☐ **Retired**

Spouse/Partner

Name *(First, Middle, Last)*	**Social Security Number**	**Birth Date *(MM, DD, YY)***

Employment Status ☐ **Full Time** ☐ **Part Time** ☐ **Self Employed** ☐ **Unemployed**	**Unemployed Date (MM, DD, YY)**

Employer Name	**Employment Length**

Gross Employment Income	☐ **Hourly** ☐ **Weekly** ☐ **Bi-weekly**

If not employed, please select all applicable reasons why:

☐ **Health Problems** ☐ **Unable to find work** ☐ **Student** ☐ **Disabled**
☐ **Laid-off** ☐ **Not seeking employment** ☐ **Retired**

Dependents

Full Name	Relationship	Birth Date (MM, DD, YY)
1.		
2.		
3.		
4.		

Provide documentation for any of the following sources of income

Income Description	Source	Monthly Income Amount
Interest/Dividends		
Pension/Retirement		
Rental Income		
Social Security		
Child Support		
Other		

Insurance

Medical Insurance	Policy Provider
☐ Yes ☐ No	

Please explain any situation we should be informed of in order to understand your inability to pay the medical balance. Additional verification may be required.

I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.

Responsible Party Signature _____ *Date* _____