Willis Knighton Health
Application for Financial Assistance for Hospital Charges

_____

Patient Name (Last, First, MI) Account Number

_____

Patient Address City State Zip Code

_____ Marital Status: Married Single Widowed

Birth Date (Month/Date/Year) Telephone Number (Circle One) Separated Divorced

A. Income: Please provide gross monthly income for each of the following persons in your household.

If patient is a minor, please provide the gross monthly income for:

Patient's Father $_____ Source_____

Patient's Mother $_____ Source_____

If patient is 18 years or older, please provide gross monthly income for:

Patient $_____ Source_____

Spouse $_____ Source_____

B. Income Verification: Please provide verification (send copies only, no original documents) for all sources of household income (acceptable documentation listed below):

- Most Recently Filed Income Tax Return
- Check Stubs
- Employer Verification
- Social Security Determination Letter
- Unemployment Determination Letter
- Workers Compensation Determination Letter
- Bank Statements
- Other (describe) _____

C. Family Size: Please provide the total number of people in the patient's household. _____
(**This number should include only those people that can be claimed as an exemption on your income tax return.)**

D. Assets and Other Resources: Please list assets or other resources available to you. (Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

Account Type	Amount
_____	_____
_____	_____
_____	_____

Signature of Patient or Responsible Party_____