

FINANCIAL ASSISTANCE APPLICATION

Stormont Vail Hospital and Cotton O'Neil Clinic Account

Guarantor # _____ Guarantor Name _____
 This information can be found on the upper right hand corner of your statement This is the name of the person to whom the statement is mailed

General Information

Patient Name _____
 (Last) (First) (M.I.)
 Person Responsible for Payment _____ Relationship to Patient _____
 Address _____
 City _____ State _____ Zip Code _____
 Please provide the phone number where you can be reached in the event we need to contact you () _____

Financial Information

Total Monthly Income

Gross Monthly Income \$

Gross Monthly Income (spouse) \$

Monthly Child Support received \$

Monthly alimony received \$

Social Security received \$

Disability received \$

Unemployment received \$

Interest Income, dividends, etc. \$

Pension Income \$

Other income \$

Total amount in Savings Acct \$

Total amount in Checking Acct \$

Total amount in other resources \$

Documentation listed below is required for proof of ALL Financial Information

Most recent Federal Income Tax forms (all forms with IRS) with W2s – If you have not filed Federal Income taxes, please explain why

Pay stubs for the last month for you and your spouse

Court document indicating the amount of child support

Court document indicating the amount of alimony

Social Security benefits letter/statement

Disability benefits letter/statement

Unemployment benefits letter

Interest and dividends income statement

Pension benefits letter

Most recent statements for other resources (CDs, money markets, stocks, bonds, mutual funds, etc.)

Copies of most recent statement(s) for savings account

Copies of most recent statement(s) for checking account

Copies of most recent statements

Number of persons supported by Total Monthly Income _____
 If different from Federal Tax Form, please explain briefly _____

I certify that the above information is true and accurate to the best of my knowledge. I understand that if I submit false information I will not be eligible for Financial Assistance. I certify that I meet the eligibility requirements needed to apply for Financial Assistance, as described on the instruction form.

Signature _____ Date _____

Return this form along with the required documents above. Failure to complete this form in full and to provide required documentation as proof of ALL Financial information **WILL** result in Financial Assistance denial. Further information may be requested pending consideration of Financial Assistance.

All required information is due back within 14 days of receipt. If you have any questions call Customer Service (785) 354-1150, (800) 637-4716, or email billinghelp@stormontvail.org