SOUTHERN COOS HOSPITAL & HEALTH CENTER
We're here for life!

Financial Assistance Application – PLEASE PRINT ALL INFORMATION

Applicant Data

Patient Name:	Phone#:	SSN:	Date of Birth:
Address:	City:	State:	Zip:

Are you: **Homeless?** Yes ☐ No ☐ **Unemployed?** Yes ☐ No ☐ **Uninsured?** Yes ☐ No ☐

Family Data - Names of all persons living in your household. Include dependent children under 18.

Spouse:	SSN:	Date of Birth:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:

Household Income

Income Information – Employment and other income sources & monthly amounts for household members. "Income Source": Name of employer or specific source of income (E.g.: SS, SSDI, Annuity, Pension, etc.)
Note: In absence of income, a letter of support from individuals providing for the patient's basic living needs is required.

Income-All Sources	Employer Name & Address	Monthly Gross	How Often?	Weekly/Monthly/Annually
		$		
		$		
		$		
		$		
		$		

If you do not file taxes, check here: ☐ **Does your family receive food stamps? Yes** ☐ **No** ☐

List additional sources of income on a separate sheet.

Does your family have these other assets? Check all that apply and include copy of a recent statement for each: ☐ Stocks ☐ Bonds ☐ 401K/IRA/Annuity ☐ Health Savings ☐ Trust(s) ☐ Real Estate (excludes primary residence)

Medical Debt (If additional space is needed, please list on a separate sheet of paper.)

Provider/Clinic Name:	Monthly Payment	Balance
	$	$
	$	$
	$	$

Extenuating Circumstances: Attach a separate page explaining any extenuating situation that you would like us to consider in making our determination.

READ CAREFULLY BEFORE SIGNING

I certify that the information in this application is correct and complete to the best of my knowledge and that the information is subject to verification and any means that Southern Coos Hospital and Health Center deems necessary. I understand that intentionally providing false information and/or submission of an incomplete application will result in a denial of my request for Financial Assistance.

Patient Signature: _____ **Date:** _____
(Or Parent/Legal Guardian if patient is a minor)

Spouse Signature: _____ **Date:** _____