

Application: Financial Assistance

Responsibility of Bill (please print)

Last Name _____ First Name _____ Middle _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Phone number _____

1. Is this application for future or past service? Future ___ Past ___ Date of Services _____

If future what are your specific needs? _____

2. Has anyone in your household applied for the County Indigent Health Care Program, Children's Health (CHIPS), or Medicaid?

Yes _____ No _____ Who _____

When _____ What is the status: Pending _____ Denied _____ Reason _____

3. Is anyone in your household pregnant? Yes _____ No _____

4. Has anyone in your household served in the military? Yes _____ No _____ Who? _____

5. Have you ever filed a workers' Compensation or motor vehicle accident claim? Yes _____ No _____ Date _____

6. Is anyone in your household eligible for Social Security benefits? Yes _____ No _____ Who? _____

7. Is anyone in your household covered by health insurance or a health savings account (HAS)? Yes _____ No _____

Who? _____

8. Does anyone else claim you on their income tax return? Yes _____ No _____ Who? _____

List all dependents, including your spouse:

Name	Age	Relationship/ Applying for benefits

MONTHLY INCOME

Do you have an income? Yes _____ No _____ Amount \$ _____

Does your spouse have an income? Yes _____ No _____ Amount \$ _____

 If yes, you must provide recent pay stubs, receipts if self-employed, proof of public assistance payments, Social Security, unemployment, workers' compensation, child support, alimony, etc. **DOCUMENTATION IS REQUIRED.**

For office use only:

Date turned in: _____ Approved Date: _____ Denial Date: _____ Reason: _____

