Nor-Lea Hospital District

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name_____ Date _____

This completed form should be attached to the required documentation and returned to the Financial Counseling Department.

Please Include:

1. Copies of your current federal tax return with all schedules, including W2's
2. Gross monthly income verification (paycheck stubs) for the last 60 days for all household members

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Patient Name_____

Social Security Number_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Responsible Party_____

Social Security Number_____ Date of Birth_____

Relationship to Patient_____ Phone Number_____

Employer_____ Work Phone_____

Total monthly gross income $_____

Additional Household Members

Name	DOB	Relationship	Name	DOB	Relationship

Describe inability to pay account balance: (Copies of monthly expenses)

_____

_____

_____

_____

We may require additional documentation to assist you. If so, we will contact you at the telephone numbers you have listed. Patients who fail to follow through in the application process, or who refuse to apply for outside programs and who potentially may have qualified, may be denied financial assistance.

Nor-Lea Hospital District

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau reports. I understand that this information is determined to be false or deceptive I will be liable for payment of charges for all services rendered. I understand that his request for financial assistance does not pertain to other healthcare providers and only pertains to Nor-Lea Hospital District. A Financial Counselor will notify applicant within 90 days of completed application.

Applicant Signature _____ Date _____

For Internal Use Only:

Account Number	*Amount*	*Account Number*	*Amount*

Counselor Name: _____ Requisition: _____

Counselor
Notes:_____
_____
_____

Patient must pursue forth eligible coverage for:

☐Please provide Medicaid denial
☐Please provide Insurance coverage for a charity w/o
☐Proof of County Indigent denial
☐Please provide proof of secondary coverage for charity w/o
☐_____

☐Approved: _____ Date: _____

☐Denied: _____ Date: _____

Reason for Approval or Denial
_____