Shenandoah Memorial Hospital
Financial Assistance Application

Last Name First Name Middle Initial

Address City State Zip

Home Phone Number Cell Phone Number

Guarantor Employer Address Phone

Spouse Employer Address Phone

If unemployed, when was last date of employment? _____Are you retired? [ ] Y [ ] N DATE _____

Your application will not be processed without copies of all income verification listed:

*****Copy of current bank statement**

*****Federal and State income tax return for current year** (if you did not file income tax, you must provide an informational only tax return prepared by a tax preparer)

Child Support_____ / _____ (amount) (# of mos received prior year)

Food Stamps_____ / _____ (amount) (# of mos received prior year)

Workman's Compensation_____ / _____ (amount) (# of mos received prior year)

VA Assistance_____ / _____ (amount) (# of mos received prior year)

Social Security Survivor Benefits_____ / _____ (amount) (# of mos received prior year)

Other Income_____ / _____ (amount) (# of mos received prior year)

Adults Living in Household

Name	Social Security #	Date of Birth	Relationship

Children Living in Household

Name	Age	Date of Birth	Relationship

Assets:_____
(Please list out Cash on Hand, Checking/Savings Account balances, Stocks & Bonds Market Value, IRA's , etc.)

Liabilites: Please provide the monthly payment amounts and balance due:

Rent/Mortgage Payment:_____ Personal Loans:_____
Finance Companies:_____ Credit Union:_____
Bank Loans:_____ Charge Accounts:_____
Food:_____ Utilities:_____
Child Care:_____ Auto Expenses:_____
Health & Life Insurance:_____ Medical Expenses:_____

I certify that the information provided is true and accurate. I will make applications and/or take necessary actions to obtain any assistance (Medicare, Medicaid, SSI, liability insurance, etc.), which may be available for the hospital services received. I will also assign or pay to the hospital any amount recovered for hospital services not to exceed the benefit provided with this application.

The Financial Assistance program is based upon current federal poverty guidelines and family size. The Shenandoah Medical Center, Inc. does reserve the right to request additional financial information to assist in the determination of eligibility for financial assistance. I understand this application will be used to determine my eligibility for uncompensated charity services provided by the Shenandoah Medical Center, Inc. and all information requested must be provided.

If any information that I have provided proves to be misrepresented, I understand Shenandoah Medical Center, Inc. will take appropriate actions to obtain payment not to exceed the benefit initially provided. I understand that as part of the review process that a credit report may be obtained to verify my financial resources. All information obtained will be kept confidential and will be protected under the patient's rights to privacy.

_____ _____
Signature of Applicant Date