APPLICATION FOR HOSPITAL FINANCIAL AID

Any approval of this request is temporary and expires 6 months from the date of approval

OUR LADY OF FATIMA HOSPITAL 200 HIGH SERVICE AVE, NO PROVIDENCE RI 02904

Patient Name:	**Guarantor: SAME AS PATIENT**
Date of Birth:	**Social Security # (if issued):**
Social Security #(if issued):	**Home Phone #:**
Home Phone #:	**Work Phone #:**
Home Address:	**Relation to Patient:**
Work Phone #:	**Address:**
Occupation/Employer:	**Address:**

Providing the information below on the patient's primary language, race & ethnicity is optional to the patient: Circle One Each

LANGUAGE:	**English**		**Non-English**
ETHNICITY:	**Hispanic**		**Non-Hispanic**
RACE:	**Asian**		**American Indian/Alaska Native**
	Black/African American		**Native Hawaiian/Pacific Islander**
	White		**Other or Multiple Races**

Please provide the following information for ALL members of the family unit, EXCEPT the Patient and Guarantor

Name & Relationship to Patient:	
Social Security # (if issued):	**Date of Birth:**
Home Address:	
Employer Name, Address & Phone:	
Name & Relationship to Patient:	
Social Security # (if issued):	**Date of Birth:**
Home Address:	
Employer Name, Address & Phone:	
Name & Relationship to Patient:	
Social Security # (if issued):	**Date of Birth:**
Home Address:	
Employer Name, Address & Phone:	

MONTHLY INCOME	**ASSETS**
Patient's Salary and Wages:	**Savings:**
Spouse's Salary and Wages:	**Checking:**
Guarantor's Salary and Wages:	**Certificates of Deposit (CDs):**
Self-Employment Income:	**Money Market Accounts:**
Child Care Income:	**Savings Bonds:**
Rental Income:	**Stocks:**
Unemployment Compensation:	**Bonds:**
Temporary Disability Insurance:	**Mutual Funds:**
Child Support:	**IRAs:**
Alimony:	**401(k)s:**
Workers' Compensation:	**403(b)s:**
VA Benefits:	**457s:**
Social Security Payments:	**Cash-In Value Life Insurance:**
Dividend & Interest Income:	**Personal Property:**
Royalties:	**2nd Home & Rental Property:**
Pensions:	**2nd Motor Vehicle:**
Public Assistance:	**TOTAL ASSETS:**
Other:	
TOTAL MONTHLY INCOME:	**TOTAL ANNUAL INCOME:**

I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if theinformation I provided is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities.

Signature:	**Date:**
Reviewer Signature:	**Approval Discount %:**
Maximum Income Allowed:	**Approved Amount: $**
Denial Comments:	**% of Federal Poverty Level:**