

5. Please indicate for ALL people living in the household, including applicant:

	PERSON 1	PERSON 2	PERSON 3
NAME of each person:	_____	_____	_____
Name of employer:	_____	_____	_____
Gross Monthly Income from:			
Employment:	_____	_____	_____
Self Employment:	_____	_____	_____
Investment Accounts:	_____	_____	_____
Real Estate Rentals:	_____	_____	_____
Unemployment Since ___/___/___:	_____	_____	_____
Retirement (Soc.Security, Pension, Annuity):	_____	_____	Savings & Investments _____
Checking Account Balances:	_____	_____	_____
Savings & CD Account Balances:	_____	_____	_____
IRA(s), 403B, 401K:	_____	_____	_____
Other savings & investments:	_____	_____	_____
Specify _____:	_____	_____	_____

Other

Automobile:	Year _____	Make _____	Model _____
Recreational Vehicle(s):	Year _____	Make _____	Model _____
	Year _____	Make _____	Model _____

4. Household Expenses:

Monthly Rent \$ _____ or Mortgage Payment \$ _____ Mortgage Loan Balance \$ _____ Property Tax Amount Not Included in Payment Amount Above: \$ _____ Value of Home \$ _____ Do You Own Property Other Than Primary Residence? Yes No If yes, Value: \$ _____ Mortgage Balance \$ _____

If other property is a business, list address: _____

Insurance (Auto/Life/Property): \$ _____ Utilities: \$ _____ Other: _____ \$ _____

Health Insurance Premium: \$ _____ Healthcare Bills: \$ _____ Other: _____ \$ _____ Living (gas, food, clothes): \$ _____ Medications: \$ _____ Other: _____ \$ _____ Alimony / Child Support: \$ _____ Child Care: \$ _____ Other: _____ \$ _____

5. ASSIGNMENT OF RIGHTS: READ CAREFULLY

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactively back to the date the bills owed. I may be liable for any and legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial, or employment information which relates directly to their healthcare or to their financial assistance eligibility. This information may be released to any healthcare providers from whom household members have south healthcare services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures might not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example Liability insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Community Care, I agree to tell the organization where I first applied of any changes, which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

_____	_____	_____	_____
Applicant Signature	Date	Co-Applicant Signature	Date