POLICY 53.05 EXHIBIT C

FINANCIAL ASSISTANCE POLICY APPLICATION

Account # (s) _____ **Date:** _____

Section One: Personal Information:

1. Patient Name: _____2. Social Security #_____

3. Street Address: _____City, State, Zip: _____

4. Guarantor: _____ 5. Service Date: _____

6. Phone# (home) _____ (work) _____ (cell) _____

7. Total Income: _____ 8. Family Size: _____

Section Two: Income Criteria

Sources of Income: _____

Gross Salary/Wages:
One month income criteria x 12: _____
Three months income criteria x 4: _____
Twelve months income criteria: _____

Documents Required:
Identification: Driver's license, SS card or birth certificate
-Income: You may provide the one month, three months or twelve months prior to date of service.
Current Pay Stubs, Profit and Loss Statement if self-employed, Previous Completed Income Tax Return

In connection with your application to participate for The Financial Assistance Discount, The Valley Hospital may require some additional information to be supplied by you. This information may be necessary to complete your application.

Please sign the bottom of this form and return it with the documentation required.

_____ _____
Signature Date