UNITY MEDICAL & SURGICAL HOSPITAL
FINANCIAL HARDSHIP APPLICATION

Application/Evaluation cannot be processed or assessed without income verification. If you have no income, please provide explanation of how your living expenses (housing, food, utilities, etc.) are paid.

Account Number(s):____

Patient Name:______________________________ **Date of Birth:**__________________________

Address:___________________________________ **Telephone #:** __________________________

Social Security#:__________________________ **Balance Totals:** ___________________________

Provide the Following on All Household Members.

Name	Date of Birth	Relationship to Patient
________________________	__________________________	___________________________
________________________	__________________________	___________________________
________________________	__________________________	___________________________
________________________	__________________________	___________________________
________________________	__________________________	___________________________
________________________	__________________________	___________________________

Income from Employment

Person Employed	Employer	Gross Pay	Per
___________________	___________________	__________________	☐Wk ☐2 Wks ☐Month
___________________	___________________	__________________	☐Wk ☐2 Wks ☐Month
___________________	___________________	__________________	☐Wk ☐2 Wks ☐Month

Household Income from Other Sources	Amount per Month
Child Support/ Alimony Received (only if patient is recipient)………………..	$_________________
Food Stamps/ TANF/ Foster Care/ Township Trusty/ Church……………………	$_________________
Income Assistance/ Project SAFE/ Lunch Programs, etc………………………..	$_________________
Pension………………………………………………………………………	$_________________
Rental Property………………………………………………………………	$_________________
Social Security/ Social Security Disability………………………………………..	$_________________
Stocks, Bonds, Annuities, Interest…………………………………………………	$_________________
Unemployment or Worker's Compensation………………………………………	$_________________
Other:____	$_________________
Total Monthly Gross Income:	$_________________

Revised – 1-11-2013

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Assets

Cash on Hand…………………………………………………………………….. $__________________

Checking Account Balance: Bank: ________________________ $__________________

Savings Account Balance: Bank: _______________________ $__________________

Stocks, Bonds, IRA, Certificates of Deposits Type/Bank____________ $__________________

Real Estate (Primary Residence)……………………………………………….. $__________________

Other Real Estate: Location_____________________________________ $__________________

Vehicles: Year/Make/Model ______________________________Value → $__________________

Year/Make/Model______________________________ Value → $__________________

Year/Make/Model______________________________ Value → $__________________

Vehicle Loan Balance__________________________________ $__________________

Total Assets: $__________________

Household Liabilities/Expenses

Cable Television / Satellite per Month …………………………………………… $__________________

Child Support / Alimony Paid per Month ……………………………………... $__________________

Credit Card Payments per Month (Total Credit Balance___________) $__________________

Grocery Expense per Month …………………………………………………… $__________________

Insurance Premiums per Month: Life____ Auto_____ Home____ Health_____ $__________________

Internet Service Provider/ DSL per Month ………………………………………… $__________________

Loan Payments per Month (Total Loan Balance_____________) $__________________

Medical Bills per Month (Total Medical Bills_____________) $____________________

Other Monthly Payments: Type________________ Balance__________ $____________________

Type________________ Balance__________ $____________________

Rent/Mortgage per Month: (Mortgage Balance______________) $__________________

Telephone…………………………Cell_____________ Home_______________ $___________________

Transportation per Month ……………………………………………………. $__________________

Utilities per Month ………………………………………………………………. $__________________

Total Monthly Payments: $__________________

Other Circumstances We Should Consider In Assisting You:

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****Please Include Verification of Income****

- ♦**IRS Form W-2**
- ♦**Pay stubs/Unemployment vouchers (3 most current months)**
- ♦**Tax Return (most current year filed)**
- ♦**Bank Statement (3 most current months)**
- ♦**Social Security/VA Benefits/Pension/Retirement letters**
- ♦**Notarized Letter (when necessary)**

I understand Unity Medical & Surgical Hospital may verify the financial information contained in this Financial Assistance Application ("Application") in connection with the Hospital's evaluation of this Application, and by my signature, does hereby, authorize my employer to certify the information provided in this Application. I also authorize Unity Medical & Surgical Hospital to request reports from any and all credit reporting agencies, as well as the Social Security Administration. I am aware that the falsification of information on this Application may result in the denial of my financial assistance. When application is received, only current balances due will be taken into consideration for assistance. Unity Hospital will not refund any self-pay payments.

Signature: ____ **Date:** ___________

Witness: ____ **Date:** ___________

Office Use Only
Approved for financial assistance No______ Yes_______ What: ______% Renewal Date________

Denial Reason____

Patient Access Coordinator: ______________________________________ Date: ________________

Business Office Director: ____ Date: ________________

Chief Financial Officer: ____ Date: ________________

Chief Executive Officer: ____ Date: ________________