FINANCIAL ASSISTANCE APPLICATION

Facility Number/Hospital Name: 02810 / Vaughan Regional Medical Center

Patient Name:_____ SS#_____DOB_____

Address: _____City_____ST_____Zip_____

Phone:_____

Dependents in Household (excluding applicant)

(This includes spouse, children under 18 under legal guardianship and all others claimed on your tax return)

NAMES First, middle and Last Name	DATE OF BIRTH	SS#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you applied for Medicaid or any other State/County Assistance?_____
If yes, please list Case Number_____ Date Applied:_____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. Additionally, I understand that in accordance with Alabama Statues, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second degree. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to quality for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature:_____ Date:_____

Witness Signature:_____ Date:_____

BELOW TO BE COMPLETED BY CUSTOMER SERVICE

	Patient	Spouse	Other	Other
Salary / Wages				
Social Security				
Pension				
Unemployment				
Worker's Compensation				
VA Benefits				
Rental Income				
Child Support				
Alimony				
Food Stamps				
Other Income				
TOTALS				