Amery Hospital & Clinic

Financial Assistance Application

Please include applicable copies of your most recent federal income tax return, last 60 days of paystubs, social security benefit letter and/or unemployment benefit letter with this application.

Name		Date of Birth	Home Phone	
Address		City	State	Zip

Other Family Members (spouse or dependents)

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

Insurance Information

Do you have insurance to cover medical expenses? __ Yes __ No

Primary Insurance		Secondary Insurance	
Name of Insurance Company		Name of Insurance Company	
Effective Date	Group Number	Effective Date	Group Number
Policy Number		Policy Number	

Employment Status

Applicant (check all that apply)

__ Employed __ Unemployment __ Retired-Social Security
__ Retired-Pension __ Income Assistance __ No Income

Other household members (check all that apply)

__ Employed __ Unemployment __ Retired-Social Security
__ Retired-Pension __ Income Assistance __ No Income

Income information for household members

Applicant		Other household members	
Type	**Annual, Wage & Hrs./Weekly**	**Type**	**Annual, Wage & Hrs./Weekly**
Wages		Wages	
Unemployment		Unemployment	
Social Security		Social Security	
Pension		Pension	
Income Assistance		Income Assistance	
Alimony		Alimony	
Child Support		Child Support	

Read and sign – Signature and date are required to process your application

I certify that the above information is true and correct. I understand that the information I have provided is subject to verification by Amery Hospital & Clinic, for review by federal and state agencies, and for other programs or related purposes. I also understand that my application and eligibility for financial assistance may be subject to the specific guidelines of the location from which I received my care.

Signature	Date