First Care HEALTH CENTER

Please complete and return by _____

FINANCIAL ASSISTANCE APPLICATION

Date:_____ Account Number(s): _____

Responsible Party Name:_____

Social Security #:_____ Date of Birth:_____

Street of Box #:_____Apt. #:_____

City:_____ State:_____ Zip Code: _____ Years There: _____

Home Phone #:_____ Work #: _____ Cell #:_____

Employment:_____ Job Title:_____

Address:_____Phone #: _____

City:_____ State:_____ Zip Code: _____ Years Employed: _____

Name and age of Dependent(s) other than spouse: _____

_____

Spouse/Significant Other:_____Date of Birth:_____Social Security #: _____

Employment:_____Job Title: _____

Address:_____Phone #: _____

City:_____ State:_____ Zip Code: _____ Years Employed: _____

Are you or your spouse offered health insurance through an employer that you elect not to purchase? Yes ❑ No ❑

Do you have a roommate who shares the expenses? Yes ❑ No ❑

Are you seeking assistance because of a work-related accident or injury? Yes ❑ No ❑

Are you seeking assistance because of a car accident? Yes ❑ No ❑

Are you a student? Yes ❑ No ❑ If yes, are you full time?_____part time? _____

Have you applied for any of the following: ❑Medicaid ❑Social ❑Security Disability ❑VA ❑Medicare ❑Migrant Health
Date(s) applied: _____

FAMILY INCOME		**ASSETS**	
Self **(Monthly Net)**:	$ _____	Life Insurance Cash Value:	$ _____
Spouse/Significant Other:	$ _____	Stocks/Bonds/Mutual Funds:	$ _____
(Monthly Net)		Retirement Plans:	$_____
Alimony/Child Support:	$ _____	Saving Accounts:	$ _____
Income from Rental Property:	$ _____	Real Estate (Net Cash Value)	$ _____
Other:	$ _____	Other:	$ _____
Total Monthly Income:	$ _____	**Total Assets:**	$ _____

REAL ESTATE AND VEHICLES **Column A**

Real Estate Description/Location	Date Acquired	Original Cost	Present Value	Balance Due	Monthly Payment
Vehicles, RV's etc.	**Year of Vehicle**	**Date Purchased**	**Purchase Price**	**Balance Owing**	**Monthly Payment**
				Total of Column A	

Monthly Expenses

Column A Total	$_____
Column B Total	$_____
Column C Total	$_____
Rent	$_____
Heat	$_____
Electricity	$_____
Water & Garbage	$_____
Telephone	$_____
Cell Phone	$_____
Cable/Satellite TV	$_____
Internet	$_____
Food	$_____
Daycare	$_____
Medical Insurance	$_____
Life Insurance	$_____
Auto Insurance	$_____
Home Insurance	$_____
Clothing	$_____
School	$_____
Vehicle Maintenance	$_____
Alimony/Child Support	$_____
Other _____	$_____
Other _____	$_____
Other _____	$_____
Total Monthly Expenses	**$** _____

PLEASE LIST ALL LOANS/DEBTS **Column B**

Credit Card & Other Loans/Debts
If you need additional space, attach another sheet of paper

Lender	Current Balance	Monthly Payments
	Total of Column B	

OUTSTANDING MEDICAL BILLS **Column C**

Medical Facility	Current Balance	Monthly Payment
	Total of Column C	

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me.

By signing this agreement, I am promising to cooperate with First Care Health Center and provide adequate information in a timely manner to resolve my bill.

Signature_____ Date _____

Signature_____ Date _____