



APPLICATION FOR FINANCIAL ASSISTANCE

Patient's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip Code _____
Social Security Number _____ - _____ - _____ Home Phone _____
Employer _____ Family Size _____
Family Member Names: _____

FINANCIAL POSITION:

Income : List Total Household Income.

Employer : _\$ _____ Unemployment: _\$ _____
Social Security: _\$ _____ Disability: _\$ _____
Child Support: _\$ _____ Other: _\$ _____

ASSETS:

Checking: yes no Savings: yes no CD: yes no Other: yes no

MONTHLY EXPENSES: list amount, if no amount list reason why

Rent/Mortgage: _____ Electric/Heating: _____
Water: _____ Food: _____
Auto Loan: _____ Auto Insurance: _____
Transportation Costs: _____
Telephone: _____ Cable/TV: _____
Installment Bills: _____
Medical/Dental: _____
Other Expenses: _____

SCREENING QUESTIONS:

- 1. Do you receive any benefits from DCF? If so what do you receive?
2. Are you Disabled? Yes No What is your disability?
Date Disability Began:
3. Do you have a child that is disabled?
Do they receive SSDI? If so how much?:

