Financial Assistance Application
Geary Community Hospital

Is this application for past services? YES _____ NO _____ Past Dates of Service _____

Where were/are services being performed? _____

Patient's Information:

_____

Last Name First Name Middle Initial Social Security Number Date of Birth

Street Address City State Zip Code

Mailing Address City State Zip Code

Please circle one: Single Married Common Law Separated Divorced Widowed

Gender: Male _____ Female _____ Language: English _____ Spanish _____ Other _____

Home Phone Number: _____ Work Phone Number: _____

Person Responsible for paying the bill:

Last Name First Name Middle Initial Social Security Number Date of Birth

Name of the Insurance Company (VA, Medicare, Commercial, etc.) Effective Date

Please indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return:

(Use an additional sheet of paper if needed)

SELF

Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent

Are services related to a workers' compensation or motor vehicle accident claim? YES _____ NO _____

Is anyone in your household: (Check all that apply)

Pregnant	**Who?**
A victim of a crime that caused injury?	**Who?**
Disabled?	**Who?**
Not a U.S citizen: **If LPR how many years? _____**	**Who?** **Immigration status: _____**
Eligible for COBRA insurance?	**Who?**
Do you have or plan to file a personal injury claim to compensate for injuries received?	**YES _____ NO _____**

Do you receive subsidized Housing, Food Stamps or Woman's infants and Children's Program (WIC)?

YES _____ NO _____

Monthly Household Income Information	**Patient**	**Spouse/ Co-Applicant**
Gross Income (before deductions)		
Self-Employment Income		
Unemployment		
Social Security/SSI (please specify)		
Retirement or Child Support		
Alimony or Child Support		
Interest and dividends from investment accounts		
Real Estate Rental Income		
Other Income		
Total Income		

Total Household Income _____

Monthly Household Expense Information:

	Total		Total
Mortgage/Rent		**Groceries**	
Electricity		**Car Payment (s)**	
Household Gas		**Day Care**	
Water/Sewer		**Child Support/Alimony**	
Phone/Cell Phone		**Student Loans**	
Cable/Internet		**Medical Expenses**	

Total Household Expense

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

INFORMATION OBTAINED FROM: _____

RELATIONSHIP TO PATIENT: _____

I am applying for financial assistance with Geary community Hospital (GCH) as billing/collection agent for the affiliated healthcare providers indicated above. I understand that it is the expectation of GCH that patients use all their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this application and supporting documents are true and complete. By signing this form, I agree to allow GCH to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to GCH for this same purpose. I understand that GCH may require more specific proof of any information on this financial assistance application (FAA) and supporting documents will be provided upon request. If any information in this FAA and supporting documents if found to be false, misleading, or incomplete, my application for assistance will be denied. GCH reserves the right to re-evaluate and/or reverse any charitable services designation if material information is not disclosed, or information was misrepresented or deliberately withheld.

APPLICANT SIGNATURE:_____DATE:_____