Financial Aid Form

☐ Approved
☐ Rejected

Answer all questions completely and to the best of your knowledge in order to prevent delaying this charity application. Include a copy of your W-2; tax return and/or 2 current pay stubs and self-employed patients need to provide a copy of their income tax returns and for Medicare patients please provide a copy of your social security check or bank statement.

Date of Application:_____

PATIENT INFORMATION

Patient Name:_____
LAST FIRST MIDDLE INITIAL

Social Security Number: _____

Address:_____ _____ / _____
STREET CITY STATE/ZIP CODE

Phone Number: _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Responsible party or spouse name: _____
LAST FIRST MIDDLE INITIAL

Social Security Number: _____

Address:_____ _____ / _____
STREET CITY STATE/ZIP CODE

Phone Number: _____

EMPLOYMENT INFORMATION

1. **Are you presently employed?** **Patient** ☐ Part Time ☐ Full Time

   Spouse ☐ Part Time ☐ Full Time

2. **Patient Employment:**

   Present
   Employer_____
   Address of Present Employer_____
   Employer Phone Number_____Length of Time Employed____yrs____mos

   Spouse Employment:
   Present Employer_____
   Address of Present Employer_____
   Employer Phone Number_____Length of Time Employed____yrs____mos

3. ***Patient Past Employment (To be answered only if unemployed)***

   Where Last Employed_____
   Address of Last Employer_____
   Employer Phone Number_____Date Last Employed_____

4. **Spouse Past Employment**

   Where Last Employed_____
   Address of Last Employer_____
   Employer Phone Number_____Date Last Employed_____

5. **Name of Nearest Relative Not Living With You:**

   _____
   Address:_____Phone Number_____
   Relationship:_____

FINANCIAL INFORMATION

Verification of Information: I hereby authorize The Fauquier Hospital, Inc. (hereinafter "Hospital") to verify any information contained herein. Further, I authorize my present or past employers to release to the Hospital any information that the Hospital requests related to my dates of employment and wages or salary. I also authorize any courts in the United States to release to the Hospital information concerning any child support that I am receiving or paying, the amount of the payments ordered to be made to or from me, and the duration of the same.

1. Number of Dependents (who you're responsible for) In Your Household Including yourself and their ages:

_____

_____

2. Do you own?

☐ Real Estate Amount of Payment _____

☐ Automobile Amount of Payment _____

3. List Your Monthly Payments:

Rent: _____

Phone: _____

Electric: _____

Credit Card(s): _____

4. Income:

Gross Family Income	_____
Public Assistance (Food Stamps, etc.)	_____
Social Security	_____
Unemployment	_____
Worker's Compensation	_____
Strike Benefits	_____
Veteran's Benefits	_____
Alimony or Child Support	_____
Military Allotments	_____
Support from Someone not Living in Household	_____
Government Pension	_____
Private Pension	_____
Income from Rental Property	_____
Amount of Savings Account	_____
Amount in Checking Account	_____

5. Do you have other accounts with The Fauquier Hospital, Inc.? ☐ Yes ☐ No

I HEREBY CERTIFY that the information provided above is true and accurate to the best of my knowledge and that this information is material. I understand the Hospital will be relying on the same and the Hospital will suffer damages if the information is false. Moreover, I understand that if this information is false the Hospital may proceed with legal action against me.

_____

SIGNATURE OF APPLICANT

_____

FOR HOSPITAL USE ONLY

Application taken by: _____ Patient Account #(s) _____

Approved by: _____ Date: _____

Rejected by: _____ Date: _____

Information Verified by: _____ Date: _____

Remarks: _____