Community Assistance Program Application

Patient:			
Account #'s			
All Questions Must Be Answered Put N/A if not applicable; use second sheet of paper for additional information			
Patient (If patient is a minor, use financially responsible parent/guardian)			
Name:		Social Security #	
Date of Birth:	Hm Phone #	Cell #	
Address:			
City:	State	Zip Code:	
How long Resided?	Marital Status:		
Previous Address:			
City:	State	Zip Code:	
Employer's Name:			
City:	State	Zip Code:	
How long employed:	Employers Phone #		

Dependents Name	Date of Birth	Social Security #	Living in Household

Nearest relative not living with you		Relationship:	
Address:			
City:	State:	Zip Code:	
Spouse 's Name:		Social Security #	
Date of Birth:	Hm Phone #	Cell #	
Address:			
City:	State:	Zip Code:	
How long Resided?			
Previous Address:			
City:	State:	Zip Code:	
Employer's Name:			
City:	State:	Zip Code:	
How long employed:	Employers Phone #		
FINANCIAL INFORMATION (Include *ALL* Household Income)			
Household Gross Income:$	Monthly Take Home Income: $		
Social Security $	Retirement/Pension $		
Certificate of Deposit $	Food Stamps $		
Stocks/Bonds?Annuities $	IRA $		
Welfare $	Monthly Payment $		
Home: Own __ Rent __ Buying __ Other _________	Other $		
Paid To:			
Property Value $	Remaining Balance$		

Vehicles:	Monthly	Remaining	Payment
Vehicles: Year/Make/ Model	**Payment**	**Balance**	**made to:**

The above financial information shall be used to determine eligibility only and will not be considered as possible source of payment.

Community Assistance Program Application (Continued)

Monthly Expenses (Include payment **only** if not deducted by your employer on your payroll check)

	Currently Due	Past Due		Currently Due	Past Due
Rent/House Payment	$	$	Child Care	$	$
Power	$	$	Phone	$	$
Gas/Oil/Heat	$	$	Gasoline	$	$
Water/Sewer/Trash	$	$	Groceries	$	$
Child Support	$	$	Health Ins.	$	$
Auto Insurance	$	$	Life Ins.	$	$
Medications	$	$	Misc.	$	$
Auto Payments	$	$	Misc.	$	$

Medical Bills, Credit Cards, Loans & Other Debts		**Current Payment**	**Past Due**
Name		$	$
City:	State:	Zip Code:	
Name		$	$
City:	State:	Zip Code:	
Name		$	$
City:	State:	Zip Code:	
Name		$	$
City:	State:	Zip Code:	
Name		$	$
City:	State:	Zip Code:	
Name		$	$
City:	State:	Zip Code:	

1. Proof of all gross (pretax) income for the responsible party. Including paycheck stubs or last year's federal tax return, child support, alimony, or social security income statement; and/or your unemployment compensation letter.

2. Proof of residency.

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Signature of Responsible Party____ Date Completed____________________

If you reported $0.00 income on the first page, please have the Support Statement below completed by the person(s) helping you and/or your family

Support Statement (To be completed by the person providing support)

I have been identified by the applicant as the person providing support. Below is a list of all services I provide the applicant:

____

____

____

____

I hereby certify that all the above information is true and correct to the best of my knowledge and belief. I understand that my signature does not make me responsible for the patient's medical charges.

Signature____ Date____________________________________

Mailing Address____________________________________City, State & Zip________________________________

Patient Insurance Information

Did you have health insurance at the time of your service? Yes_____ No _____
If Yes, please attach a copy of your card, front and back and fill out the following:
Name of Insurance Company:____

Policy Number __________________________________ Group Number________________________________

Insurance Phone Number____

Hospital Use Only

TVHC Representative Signature _______________________________ Date Application Received:______________