**Head of Household Information:**

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

Street Address City State Zip

Mailing Address City State Zip

Please check appropriate box: Single Married Common Law Separated Divorced Widowed

Home Phone: Work Phone:

**Employer Information:**

Employer Name

Employer Address City State Zip

**Please Indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return:** (Use additional sheet of paper if needed)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship to Patient | Date of Birth | Social Security Number | Tax Dependent (Y/N) |
| 1. | **Self** |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4 |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

Are the 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 than caused injury Who?

 Disabled Who?

 Not a U.S. Citizen Who?

 If LPR (Lawful Permanent Resident) how many years? Immigration status:

 Do you have or plan to file a personal injury claim Yes No to compensate for injuries received?

 Have you applied for Medicaid? Yes No

 Date Applied: Date Denied:

**Monthly Household Income Information:**

|  |  |  |
| --- | --- | --- |
|  | **Patient** | **Spouse/Co-Applicant** |
| Gross Income (before deductions) |  |  |
| Self-Employment Income |  |  |
| Unemployment |  |  |
| Social Security/SSI (please specify): |  |  |
| Retirement (Pension, Annuity) |  |  |
| Alimony or Child support |  |  |
| Interest and Dividends from Investment Accounts |  |  |
| Real Estate Rental Income |  |  |
| Other Income |  |  |
| **Total Income** | **$** | **$** |
|  | **Total House Hold Income** | **$** |

**Monthly Household Expense Information:**

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

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

**This section needs filled out In case of an overnight stay at the Hospital.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Assets** |  |  |  |  |  |
| **Personal Items** | **Estimated Value** | **Cash or Cash Equivalent** | **Estimated Value** | **Investments** | **Estimated Value** |
| Home |  | Checking Account |  | Retirement account |  |
| Vehicle |  | Savings Account |  | Mutual funds |  |
| Vehicle |  | Certificates of Deposit |  | Farm or Business |  |
| Furniture & Equipment |  | Life Insurance (cash value) |  |  |  |
| Second Home or Property |  | Other |  |  |  |
| Other |  |  |  |  |  |
| **Assets Total** | **$** |  |  |  |  |
| **Liquid Assets Total** | **$** |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Liabilities** |  |  |
| **Loan Balances** | **Estimated Debt** | **Monthly Payment** |
| Mortgage loan |  |  |
| Home equity loan |  |  |
| Car loans |  |  |
| Real estate loans |  |  |
| Student loans |  |  |
| Other loans |  |  |
| **Other Outstanding Debt** |  |  |
|  |  |  |
|  |  |  |
| **Liabilities Total**  | **$** |  |

I am applying for financial assistance with Kearny County Hospital. I understand that it is the expectation of Kearny County Hospital that patients use all of 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 Kearny County Hospital to verify my employment for the purpose of determining eligibility for financial assistance. I understand that Kearny County Hospital may require more specific proof of any information on this FAA and supporting documents will be provide upon request. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. Kearny County Hospital reserves the right to re-evaluate and/or reverse any charitable service designation material information is not disclosed, or information was misrepresented or deliberately withheld, or if I (or my heirs)make demand for a file a civil action against a third party for personal injuries or damages )including medical charges/expenses). I understand and agree that any financial assistance granted by Kearny County Hospital may not be used by me or my legal representatives in any negotiations, settlements or lawsuit for the purpose of enhancing an award of monetary damages. Should this occur, I agree that Kearny County Hospital has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that nay hospital that rendered medical services to the patient named above may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

Applicant’s Signature Date

Co-Applicant’s Signature Date

**A Financial Counselor is available Monday through Friday 8:30am to 4:30pm. For assistance please call (620)355-7112 ext. 1541. \* Se Habla Español.**