Financial Hardship Application

Patient Information			
Patient Name			Date
Patient Address			Phone
Patient City/State/Zip			How long at this address?
Responsible Party (if other than Patient)		Relationship	
Address			Phone
City/State/Zip			How long at this address?
Total number of Dependents		Health Insurance Provider	Policy Number

Banking Information		
	Description	**Cash Value**
Checking Account (List Bank Name)		$
Savings Account (List Bank Name)		$
Other Accounts/Investments (List Name)		$
	Totals	$

Income			
Patient's Employer	Title		Years Employed
Spouse's Name			Spouse's Phone
Spouse's Employer	Title		Years Employed
1. Patient's Gross Income	☐ per month ☐ per year	After taxes and deductions	
2. Spouse's Gross Income	☐ per month ☐ per year	After taxes and deductions	
3. Social Security Income	☐ per month ☐ per year	After taxes and deductions	
4. Pension or childcare/alimony support	☐ per month ☐ per year	After taxes and deductions	
5. Other Income	☐ per month ☐ per year	After taxes and deductions	
Description of Other Income		After taxes and deductions	

Verification is required - please attach copies to show proof of income

Monthly Obligations

Please List All Debts - Verification is Required

		Total Owed	Monthly Payment
1. Household ☐ Own ☐ Rent		$	$
2. Second Mortgages/ Home Equity Loans		$	$
3. Utilities Electric, Gas, Water, HOA, etc.			$
4. Telephone, Cable TV, Internet			$
5. Average Food Costs			$
6. Automobile(s)	Payments	$	$
	Insurance	$	$
7. Charge Account(s), Credit Card(s), (List):			
a)		$	$
b)		$	$
c)		$	$
8. Medical / Dental Bills		$	$
9. Child Support		End Date	$
10. Alimony		End Date	$
11. Other Loans		$	$
12. Other Expenses (explain)			
a)		$	$
b)		$	$

13. Liens or Judgments: Do you have any judgments or liens outstanding? ☐ Yes ☐ No

Required Documents

Please provide a copy of your most recent income tax return filed with the IRS, Pay Stubs, and Banking Statements.

Certification

I certify that the information on this application is true and complete to the best of my knowledge. I understand that falsification of or failure to provide complete information requested on this application may result in a denial of financial assistance or financial agreements currently in affect.

Patient or Responsible Party Signature: _____ Date: _____

Date Received: _____ Cl

earSky Health CEO Approval _____

Business Office Approval: _____ Date: _____