

Financial Assistance Application Form

Patient* Information:

Name: _____
Address: _____

Phone: _____
SSN: _____

Spouse Information (if applicable):**

Name: _____
Address: _____

Phone: _____

Marital Status (circle one): Married Single Divorced Widowed Unmarried Partnered

Employer Name: _____
Employer Address: _____

Employer Phone: _____

Employer Name: _____
Employer Address: _____

Employer Phone: _____

Family Information:

Please list all persons living with you that you claim as dependents on your Federal Income Tax Return:

Name:	Age:	Relationship to you:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Income Information:

Patient's gross monthly income: _____ Spouse's gross monthly income: _____
Other sources of income: _____ Alimony/Support payments: _____

By signing this form, I agree to allow NorthBay Healthcare to check my and my spouse's employment and credit to determine my eligibility for financial assistance. I understand that I may be required to provide proof of the information requested.

Signature of Patient or Legal Guardian

Date

Signature of Spouse

Date

Return this completed form to the registration desk or mail it to NorthBay Healthcare, Patient Financial Services, 1200 B. Gale Wilson Blvd., Fairfield, CA 94533.

*This document is to be completed by the patient's legal guardians if the patient is a minor.

** "Spouse" includes a patient's or guardian's legally registered domestic partner.