

# Financial Assistance Application



**SAN ANTONIO**  
REGIONAL HOSPITAL

Date: \_\_\_\_\_

Account/FIN#: \_\_\_\_\_

Patient Last Name:	First:	Middle:	Social Security #	Birthdate (mm/dd/yyyy)
Patients Address: (Hospital Address if Homeless)		How long?	Best Contact Phone #:	
City	State	Zip	Marital Status	

Responsible Party's Name <i>(If different from above)</i>	Social Security #	Birthdate (mm/dd/yyyy)	Best Contact Phone #:
Employer Name and Full Address (Responsible Party)			
Employer Phone #:		Monthly Gross Pay \$:	
Other Employer Name and Full Address (Responsible Party)			
Employer Phone #:		Monthly Gross Pay \$:	
If Unemployed, name of Last Employer and Full Address:			
Last Employment Dates: From _____ To / Last Day Worked _____			

List Patients Household Members/Dependents:	Birthdate	Relationship	Employed By

**Assets:**

Rent Home <input type="checkbox"/> <input style="width: 50px; height: 15px;" type="text"/> Own Home <input type="checkbox"/> <input style="width: 50px; height: 15px;" type="text"/> Estimated Value of Property: _____ Do you own other property? Yes / No If yes, estimated total value: _____ Checking Account Balance: \$ _____ Savings Account Balance: \$ _____	Do you own automobiles? Yes / No If yes, estimated value: _____ Make: _____ Model: _____ 403(b) or 401(k): \$ _____ Stocks/Bonds: \$ _____ Total Assets: \$ _____
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Monthly Income		Monthly Expenses	
Wages - Self	\$	Mortgage/Rent	\$
Wages - Spouse	\$	Utilities	\$
Wages - Other Family Member within household	\$	Telephone	\$
Self Employment	\$	Food	\$
Public Assistance	\$	Finance/other loans total	\$
Social Security	\$	Auto Loans	\$
Unemployment Compensation	\$	Medical Insurance	\$
Alimony/Child Support	\$	Auto Insurance	\$
Military Family Allotments	\$	Medication	\$
Pensions	\$	Other expenses, please list	\$
Income from dividends, Interest, Rentals	\$		\$
Any other source of income	\$		\$
<b>Total Monthly Household Income:</b>	\$		\$
			\$
		<b>Total Monthly Expenses</b>	\$

\* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge

\* I agree to tell the provider of services within 10 days, if there are any changes in my (or the persons on whos behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.

\* I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by San Antonio Regional Hospital.

\* I authorize San Antonio Regional Hospital to verify the information I provided and check my credit history using Experian or other financial tools in order to evaluate this application for Financial Assistance consideration.

\_\_\_\_\_  
Patient/Applicant Signature

\_\_\_\_\_  
Drivers License/ID #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouses Signature

\_\_\_\_\_  
Drivers License/ID #

\_\_\_\_\_  
Date