Financial Assistance Program
Application Form

Patient Information*

Name: _____
Address: _____
Phone: _____
SSN: _____

Spouse Information (if applicable):

Name: _____
Address: _____
Phone: _____
SSN: _____

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

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 in family unit including parents (if under 18), spouse, registered domestic partner, dependent children under 21 or any age if disabled; caretaker relatives/parents/dependent children.

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

Income Information:

Patient's gross monthly income: _____
Other sources of income: _____

Spouse's gross monthly income: _____
Alimony/Support payments: _____

By signing this form, I agree to allow NorthBay Health 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 Health, Financial Counseling Unit, 1200 B. Gale Wilson Blvd., Fairfield, CA 94533.