Date: ________________________

1. **Patient Information:**

Last Name ______ First Name ______ Social Security Number ______

Street Address ______ Date of Birth ______

City ______ State ______ Zip Code ______ Telephone Number ______

Medical Record Number (if available) ______

Residency Status: ☐ Citizen of the US ☐ Visitor in the US ☐ Visa

2. **Family Information:** List your spouse and/or any dependent children living in your household (listed on your tax return). If more space is necessary, please attach a separate document.

Name of dependent	Relationship to applicant	Date of Birth	Age

3. **Income Information:**

Source of Income	Patient/Responsible Party Enter Amount Per Month	Spouse or Partner Enter Amount Per Month
Gross Wages/Earnings(Before Taxes)		
Supported by Other Individual		
Child Support/Alimony Received		
Disability Benefits		
Pension Benefits		
Self Employment, Business, Rental Income Received		
Social Security/SSI Benefits		
Unemployment Benefits		
Workers Compensation		
Other Income (Interest, Stocks, Pending Settlements, Assets, etc.)		
Total Income		

4. **Expense Information:**

Expenses	Monthly Payment
Mortgage/Rent	
Auto Loan/Lease	
Medical Bills	
Utilities	
Credit Card/Other	
Total Expense	

5. **Additional Information:**

☐ Attach Proof of denial for Medical Assistance or status of current Medicaid application

☐ Attach Proof of household Income (last 3 pay stubs)

☐ Attach a copy of 3 most recent bank statements

☐ Attach a copy of the 2 most recent tax returns

Are you a veteran? Y ☐ N ☐

Are you disabled? Y ☐ N ☐

Do you have medical insurance? Y ☐ N ☐ ____

By signing below, I certify that everything I have stated on this application and any attachment is true. I understand that any incorrect, incomplete or false information on this form could result in rejection of my application for financial assistance. I acknowledge that I understand that the information which I submit as part of this application is subject to disclosure to federal and/or state agencies and I give my permission for Gaylord Specialty Healthcare to share this information with others to process this application and that more information may be requested before my eligibility can be determined. All information will remain confidential under HIPAA federal regulations.

____ ____________________

Signature of Applicant or person acting on behalf of Applicant **Date**

____

Print Name of Applicant

____ ____________________

Signature of Witness **Date**

____

Print Name of Witness