FINANCIAL ASSISTANCE APPLICATION

AcuitySpecialty*Hospitals*
of Ohio Valley

Patient Name: _____ Account# _____

Date of Birth: ____/____/____ Social Security# _____

Responsible Party: _____
Address: _____ City: _____
State: _____ Zip Code: _____ How Long At This Address: _____

Phone: ____-____-____ Number of Dependents: _____

Employer: _____ Address: _____

Make/ Model of Car: _____ Year: _____

Make/ Model of Car: _____ Year: _____

Home: _____ Own _____ Rent How Long _____

Income Per Month		Expenses Per Month	
Patient Net		Loans	
Resp Party Net		Mortgage/ rent	
Spouse Net		Food	
Rental Property		Car Payment	
Alimony		Utilities	
Child Support		Gas	
VA		Water	
Social Security		Phone	
Retirement		Cable/ Sat	
Dividentds/ Interest		Credit Cards	
Unemployment		Child Care	
		School/ Tuition	
Total Income		Insurance (Med/ Car)	
Income		Child Support/ Alimony	
Expenses		Other	
Avail Cash Per Mo.		Total Expenses	

Banking

Checking _____ Yes _____ No Name of Bank:_____
Savings _____ Yes _____ No Name of Bank:_____

I understand that the information submitted is subject to verification by Acuity Specialty Hospital and certify that the above information is true and correct to the best of my knowledge.

Applicant: _____ Date:_____