ST. MARY'S MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION

Patient's Last Name	Patient's First Name	Middle Initial	Date of Application	Patient Account No.	Patient's Date of Birth

Patient's Home Address	Patient's City	Patient's State	Patient's Zip Code

Social Security No.	Home Phone Number	Work Phone Number	Name of Guarantor	Relationship to Patient

Guarantor's Address	Guarantor's City	Guarantor's State	Guarantor's Zip Code

Guarantor's Employer	Guarantor's Employer Address	Guarantor's Employer Phone No.

Name of Dependent(s) Living With You	Income	Relationship	Age
1.			
2.			
3.			
4.			
5.			
6.			

Total Number of Qualifying Dependents: _____

Yearly Wage Calculation:_____

_____

_____

_____

Guarantor Signature:_____ **Date:**_____

******FOR OFFICE USE ONLY******

Financial Counselor Signature:_____
Approved by:_____ **% Amount Approved:**_____ **Date:**_____