Franklin General Hospital/Franklin Medical Center
Financial Assistance Application

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels. **Incomplete forms will not be processed. Income verification of current Income Tax Return, last three month's of paycheck stubs and letter of denial from Department of Human Services that you are not eligible for TXIX must be submitted for this form to be considered complete.** Information must be submitted for the individual applying and spouse or significant other living within the same household.

Applicant:	Spouse:
SSN: DOB:	SSN: DOB:
Address:	Address:
Phone/Cell Phone:	

Household Gross Monthly Income: (Include all earned and unearned income)

Salary/Wages $_____ Child Support $_____ Alimony $_____ Social Security $_____

Veteran's Benefits $_____ Retirement/Pensions $_____ Workman's Comp/Unemployment Benefits $_____

Interest Earnings $_____ Dividends $_____

Other Income: $ _____ Description: _____

If Income is $0.00 (zero) explain:

Resources:	Other Property Values:
Checking Account Balance: _____	Recreational Vehicles $_____ Description: _____
Savings Account Balance: _____	Second Home $_____

Dependents:

Name	Date of Birth	Name	Date of Birth
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Please indicate other financial assistance programs applied for within the last year (social security disability, Medicaid, etc.)

Please provide or attach any information you feel would be helpful in understanding your current situation.

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. **I understand that I must provide verification of income, dependents, bank statements, pay vouchers and tax statements.** I understand that a credit report may be used as part of the assistance determination process.

Patient Signature: _____ Date: _____