



**BATES COUNTY MEMORIAL HOSPITAL
AND FAMILY CARE CLINICS**

Rich Hill Clinic, Adrian Clinic, Nursery St. Clinic, High St. Clinic

FINANCIAL ASSISTANCE APPLICATION

Renewal Yes No

Valid _____ to _____

(Office Use Only)

Non Bates County Resident Family Care Clinics Only

Last Name		First Name		Middle I.	DOB	Age	Telephone No.	County of Residence
Street Address			Apt No.	City	State	Zip Code	Marital Status	# of Dependents
Employer Name		Employer Address, City, State & Zip Code						
How long employed?		Employer Telephone No.			Position Title		Social Security No. (Optional)	

Last Name		First Name		Middle I.	DOB	Age	Social Security No. (Optional)	
Employer Name		Employer Address, City, State, & Zip Code						
How long employed?		Employer Telephone No.			Position Title			

Last Name	First Name	DOB	Age	Relationship to Head of Household	Social Security No.

INCOME-- OFFICE USE ONLY

GROSS INCOME	HOURLY	MONTHLY	QUARTERLY	YEARLY
Primary Wages				
Secondary Wages or other income				
Social Security Income				
Pension				
Disability				
Food Stamps				
Rental Income				
Alimony / Child Support				
Unemployment				
State Assistance				
Other (total household income required)				
TOTAL				

I hereby certify that I have not knowingly withheld any information contained on this application and that all information disclosed is correct to the best of my knowledge.
I give permission for my information to be verified with the IRS or other resources to approve my application.

X		X	
Patient / Responsible Party Signature	Date	Spouse/Partner Signature	Date
Bates County Memorial Hospital Representative	Date	Department	Nov-15