Women Caring For Women
Financial Assistance Application

SAN ANTONIO REGIONAL HOSPITAL

Date: _____

Account/FIN#: _____

Patient Last Name:	First:	Middle:	Social Security #	Birthdate (mm/dd/yyyy)

Patients Address: (Hospital Address if Homeless)	How long?	Best Contact Phone #:

City	State	Zip	Marital Status

Responsible Party's Name *(If different from above)*	Social Security #	Birthdate (mm/dd/yyyy)	Best Contact Phone #:

Employer Name and Full Address (Responsible Party)		
Employer Phone #:		Monthly Gross Pay $:
Other Employer Name and Full Address (Responsible Party)		
Employer Phone #:		Monthly Gross Pay $:
If Unemployed, name of Last Employer and Full Address:		
Last Employment Dates: From	To / Last Day Worked	

List Patients Household Members/Dependents:	Birthdate	Relationship	Employed By

Assets:

Rent Home ☐

Own Home ☐ Estimated Value of Property: _____

Do you own other property? Yes / No If yes, estimated total value: _____

Checking Account Balance: $_____

Savings Account Balance: $ _____

Do you own automobiles? Yes / No If yes, estimated value: _____

Make: _____ Model: _____

403(b) or 401(k): $_____

Stocks/Bonds: $_____

Total Assets: $ _____

Monthly Income		**Monthly Expenses**	
Wages - Self	$	Mortgage/Rent	$
Wages - Spouse	$	Utilities	$
Wages - Other Family Member within household	$	Telephone	$
Self Employment	$	Food	$
Public Assistance	$	Finance/other loans total	$
Social Security	$	Auto Loans	$
Unemployment Compensation	$	Medical Insurance	$
Alimony/Child Support	$	Auto Insurance	$
Military Family Allotments	$	Medication	$
Pensions	$	Other expenses, please list	$
Income from dividends, Interest, Rentals	$		$
Any other source of income	$		$
Total Monthly Household Income:	$		$
			$
		Total Monthly Expenses	$

* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge
* I agree to tell the provider of services within 10 days, if there are any changes in my (or the persons on whos behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.
* I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by San Antonio Regional Hospital.
* I authorize San Antonio Regional Hospital to verify the information I provided and check my credit history using Experian or other financial tools in order to evaluate this application for Financial Assistance consideration.

Patient/Applicant Signature	Drivers License/ID #	Date
Spouses Signature	Drivers License/ID #	Date