LIFESPAN'S APPLICATION FOR HOSPITAL FINANCIAL-AID

Any approval of this request is temporary and expires 12 months from the date of approval

Hospital: **Newport Hospital**	Date:
Patient Name:	Guarantor:
Date of Birth:	Social Security #(if issued)
Social Security #(if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address: Own/Rent:	Home Address: Own/Rent
Occupation & Employer:	Occupation & Employer:
Employer Address:	Employer Address:
Type of ID & #:	Type of ID & #:
Is visit related to a work injury or Accident? Yes or No - If Yes, please provide Insurance information. *(If yes, please attach explanation)*	
Are you being claimed as a dependent? Yes or No	
Number of Dependents (including self):	
Do you collect SNAP (food stamps) Yes/No if yes, please provide current letter.	
Are you currently staying in a Shelter Yes/No if yes, please provide a letter from the Shelter.	
Have you applied for GPA/Medical Assistance Yes or No if yes when:	
Have you applied for Social Security Disability? (SSDI) Yes/No If yes when:	
Do you have minor children? Yes/No if yes do you live with them? Yes/No	
Please provide the following information for ALL members of the family unit (if they are not listed on the Federal Income Tax Form).	
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address:	Home Address:
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address:	Home Address:
Monthly Income	**Assets**
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Child Care Income:	Money Market Accounts:
Rental Income:	Saving Bonds:
Unemployment Compensation:	Stocks:
Temporary Disability Insurance:	Bonds:
Child Support:	Mutual Funds:
Alimony:	IRAs**:**
Workers' Compensation:	401(k)s:
VA Benefits:	403(b)s:
Social Security Payments:	457s:
Dividend & Interest Income:	Cash-In Value Life Insurance:
Royalties:	Personal Property:

Pensions:	2nd Home & Rental Property:
Monthly Income Cont.:	**Assets Cont:**
Public Assistance:	2nd Motor Vehicle:
Other:	Total:
Monthly Income:	
Annual Income:	Total Monthly Expenses:
IF YOU LIST NO INCOME WHAT HAS BEEN YOUR SOURCE OF SUPPORT? Use separate sheet of paper if needed.	

Please be sure to enclose a copy of your most recent Federal Income Tax Filing and the last two paycheck stubs.

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."	
Signature:	Date:

Action Taken By The Hospital

CHECK OFF LIST

Pay Stubs_____ **Food Stamp Letter_____** **Tax Returns_____**

Credit Report_____ **Other Documentation_____** **Date verified with E.D.S./GPA_____**

If non-Resident required documentation:_____

Date:_____ **NOT Approved:_____** **Reason:_____**

Approved: _____ **Account#: _____** **Expiration Date:_____**

Comments: _____

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_____ _____

Authorized Signature **Administrative Approval**