UAB
Medical West
a member of the UAB Health System

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Information

Name_____ Date of Birth_____
(Last) (First) (M.I.) (Month/Day/Year)

Present Address_____
(Street/Apt. No.) (City/State/Zip)

Telephone Number: Home _____ Work_____

Social Security Number_____

Employer Name/Address_____

Responsible Party Information

Name_____ Date of Birth_____
(Last) (First) (M.I.) (Month/Day/Year)

Present Address_____
(Street/Apt. No.) (City/State/Zip)

Telephone Number: Home _____ Work_____

Social Security Number_____ Relationship to Patient_____

Employer Name/Address_____

List All Persons Residing in the Household:

Head of Household_____ Spouse_____

Children or Other Dependents	Age	Relationship

Did you receive financial assistance within the last year?__Yes__No If yes, from what facility?

ASSETS	Balance		Value
Checking Accounts	$	Home	$
(Name of Institution)		*Own or Rent?*	
Savings/Money Market/CD	$	Vehicle #1	$
(Name of Institution)		Vehicle #2	$
IRA/Pension/401K	$	Vehicle #3	$
Other Accounts	$	Other Assets(List)	$
	TOTAL ASSETS $_____		

INCOME	Monthly	EXPENSES	Monthly
Wages/Salary (yourself)	$	Rent/Mortgage Payments	$
(spouse)		Food	
(others)		Utilities (gas/electric, phone, water)	
Dividend and Interest		Car Note	
Rental Income		Other Loan Payments	
Pension Income		VISA/Master Card	
Child Support Income		Other Charge Accounts	
Alimony Income		Cable TV	
Social Security Benefits		Cellular Phones	
V.A. Benefits		Child Support	
Unemployment Compensation		Alimony	
Public Assistance/Welfare		Child Care	
		Monthly Medications	
If none, how are your food, housing and		Education /Tuition	
transportation expenses met?			
TOTAL INCOME	$	TOTAL EXPENSES	$

- For the household income(s) listed above, I have attached a copy of all most recent W-2's or 1099 forms, most recent pay stubs, prior year's tax return, and financial statements, if self-employed. (If unable to work, a letter from your physician may be required.)
- I certify that the information provided in this application is true and complete.
- I understand that the information provided may be subject to verification by UAB Medical West, including credit scores.
- I agree to immediately report to UAB Medical West any changes in financial circumstances, changes in household, damages or liability settlements received that relate to the charity being requested.
- I agree to accept responsibility for my bill if I am not eligible for assistance.
- I certify that I am a U.S. citizen.

_____ _____

Signature of Responsible party Date

HOSPITAL USE ONLY: Billed Amount$_____
Comments:
Approved_____Date_____
Denied_____ Date_____