River's Edge Hospital & Clinic Community Care
Application for Financial Assistance

A. Responsible Party

First Name_____Last Name_____Int._____
Address_____City_____State_____Zip_____
Phone ( )____-_____ Date of Birth_____/_____/_____Relationship to Patient_____

B. Dependents (Including spouse)

Name(s)	D.O.B.	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other members of your household

Name(s)	Relationship
_____	_____
_____	_____

C. Employer_____

Your Occupation_____
Employer's Phone # ( )____-_____
Current rate of pay _____

(Please include copies of recent pay stubs or unemployment benefits)

Does your employer offer you health insurance? YES_____ NO_____ (check one)

D. Assets/Income

Value of Checking Account: $_____
Value of Savings Account: $_____
Value of Stocks/Bonds : $_____
Total income reported on most recent Federal Tax Return*: $_____
Total income reported on Federal Tax Return for household members: $_____
Income from child support: $_____
Income from alimony: $_____

***Please attach a copy of your most recent Federal Tax return; incomes must be verified. Application will not be reviewed if all necessary information is not received. Students who are claimed by parents as dependents for tax purposes must include both parents' and the student's tax returns.**

E. Monthly Expenses	Unpaid Balance	Monthly Balance
Rent/Mortgage	$_____	$_____
Medical	$_____	$_____
Credit cards/loans	$_____	$_____
Groceries	$_____	$_____
Utilities	$_____	$_____
Auto loan/Gas/Repairs	$_____	$_____
Child Care	$_____	$_____
Insurance Premiums	$_____	$_____
Other	$_____	$_____

Additional information you'd like to convey:

_____

_____

The information on this application is true and correct to the best of my knowledge. I authorize River's Edge Hospital & Clinic to verify this information with my employer, bank or any other financial institution or credit reporting agency.

Date:_____Guarantor's Signature_____

Date: _____REHC Staff Signature_____

Full eligibility_____Partial Eligibility_____Not Eligible_____

Please return completed application and income verification to River's Edge Hospital & Clinic, Attn. Community Care Coordinator. For any questions call 507-934-7303. REHC reserves the right to modify this program.