



Exhibit B
APPLICATION FOR FINANCIAL ASSISTANCE

Patient Account Number(s) _____

Application Name: _____ SSN _____ Birthday _____

Spouse/Partner Name: _____ SSN _____ Birthday _____

Address _____ City _____ State _____ Telephone _____ Email _____

Family Status: List any spouse, domestic partner, or dependent children

Name: _____ Age _____ Relationship _____

Name: _____ Age _____ Relationship _____

Name: _____ Age _____ Relationship _____

Name: _____ Age _____ Relationship _____

Family Size: _____

(Use supplemental sheet if needed and check here ☐)

OTHER INFORMATION

MEDICAL INSURANCE- Please provide a photocopy of the patient's medical insurance cards

Primary Insurance _____ Policy # _____

2nd Insurance _____ Policy # _____

Prescription Drug Plan _____ Policy # _____

Other Coverage _____

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____

Contact Person & Telephone: _____

If Self-Employed Name of Business: _____

Employer: _____ Position: _____

Contact Person & Telephone: _____

If Self-Employed Name of Business: _____

The following is a true statement of all monthly income:

1. MONTHLY INCOME	AMOUNT PER MONTH
From Social Security Benefits ... Direct Deposits to bank?	\$ _____
From Supplemental Social Security Direct Deposit to bank?	_____
From Other Government Agencies (Federal, State or City)	_____
Civil Service # _____ R.R. Retirement # _____	_____
From Veteran's Pensions	_____
From Company Pensions. Name of Company _____	_____
From Union Pensions. Name of Union _____	_____
From Other Pensions ... Name _____	_____
From Foreign Governments, including Pensions, Restitutions and Indemnification Payments	_____
Give Details _____	_____
From Interest on Bank Accounts	_____
From Dividends on Securities	_____
From Interest on Securities (Treasury Notes, Corporate Bonds, etc.)	_____
From Insurance Payments or Annuities. Name of Company _____	_____
From Real Estate (Rents, Interests, etc.)	_____
From Bequests, Legacies, or Trusts. Name of Estate or Trust _____	_____
Others, (Relatives and/or Friends, etc.) _____	_____
Total Monthly Income	_____

(Use supplemental sheet if needed and check here ☐)

I hereby declare that each and all of the foregoing statements are true, correct and complete. I also understand that Exhibit B is an integral part of my application and that my application may be rejected for any incorrect and incomplete information given herein.

 Signature of Applicant or Designee

 Date