NORTHBAY HEALTHCARE

Financial Assistance Application Form

Patient* Information:

Name: _____
Address:_____
_____
Phone:_____
SSN:_____

Spouse Information (if applicable):**

Name: _____
Address:_____
_____
Phone:_____
_____

Marital Status (circle one): Married Single Divorced Widowed Unmarried Partnered

Employer Name:_____
Employer Address:_____
_____
Employer Phone: _____

Employer Name:_____
Employer Address_____
_____
Employer Phone: _____

Family Information:
Please list all persons living with you that you claim as dependents on your Federal Income Tax Return:

Name:	Age:	Relationship to you:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Income Information:

Patient's gross monthly income:_____
Other sources of income: _____

Spouse's gross monthly income:_____
Alimony/Support payments: _____

By signing this form, I agree to allow NorthBay Healthcare to check my and my spouse's employment and credit to determine my eligibility for financial assistance. I understand that I may be required to provide proof of the information requested.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Spouse Date

Return this completed form to the registration desk or mail it to NorthBay Healthcare, Patient Financial Services, 1200 B. Gale Wilson Blvd., Fairfield, CA 94533.

*This document is to be completed by the patient's legal guardians if the patient is a minor.
** "Spouse" includes a patient's or guardian's legally registered domestic partner.