



# FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME	LAST	FIRST	MI.	ACCOUNT NUMBER (IF KNOWN)
--------------	------	-------	-----	---------------------------

## A. APPLICANT

PATIENT NAME OR PARENT / GUARDIAN, IF APPLYING ON BEHALF OF THE PATIENT	LAST	FIRST	MI.	DATE OF BIRTH
HOME ADDRESS	CITY	STATE	ZIP	BEST PHONE NUMBER ( )
EMPLOYER'S NAME AND ADDRESS	POSITION	YEARS THERE	BUSINESS PHONE ( )	

## B. DEPENDENTS

YOU (1) + SPOUSE  + # OF CHILDREN  + # OTHER DEPENDENTS  = TOTAL DEPENDENTS

LIST NAME, AGE, AND RELATION: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## C. GROSS INCOME (PAST 12 MONTHS)

PATIENT	PER YEAR	DEPENDENTS	PER YEAR
Average Weekly Hours _____	Hourly Rate \$ _____	Weekly Hours _____	Hourly Rate \$ _____
	Weekly Salary \$ _____		Weekly Salary \$ _____
Overtime .....	\$ _____	<b>ANNUAL INCOME</b>	
Commissions .....	\$ _____	Dependent 1: _____	\$ _____
Dividends / Interest .....	\$ _____	Dependent 2: _____	\$ _____
Gross Rental Income .....	\$ _____	Dependent 3: _____	\$ _____
Business / Self-Employment .....	\$ _____	Dependent 4: _____	\$ _____
Social Security .....	\$ _____	Dependent 5: _____	\$ _____
Workers Compensation .....	\$ _____	Dependent 6: _____	\$ _____
Military / Pension .....	\$ _____	Dependent 7: _____	\$ _____
Unemployment Compensation .....	\$ _____	Dependent 8: _____	\$ _____
Food Stamp Income .....	\$ _____	Other: _____	\$ _____
Alimony / Child Support (this is income) .....	\$ _____		
Other _____	\$ _____		
<b>TOTAL</b>	<b>\$ _____</b>	<b>TOTAL</b>	<b>\$ _____</b>

## D. INCOME VERIFICATION

This application will be considered incomplete and will not be processed unless proof of income is attached. I have attached the following: (Please Check)

- Last Federal Income Tax Return (If Filed) OR W-2/1099 for each dependent if no tax return filed (REQUIRED)
- Last three pay checks for patient and all dependents (REQUIRED)
- Governmental Check Stubs (VA/SSI/SOC. SEC./STATE)
- Other: \_\_\_\_\_

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Applicant Signature

\_\_\_\_\_  
Date

**ATTACH ANY COMMENTS TO FURTHER EXPLAIN YOUR FINANCIAL CONDITION.**

I (or we) certify that all information herein is true and complete. I (or we) hereby authorize the Lifelight of Maine, its agents, employees, to whom this applications is made, or any credit bureau or other investigative agency employed by said Organization to investigate any references herein listed or statements or other data obtained from me (or us) or from any other person (or persons) pertaining to my credit and financial responsibility.