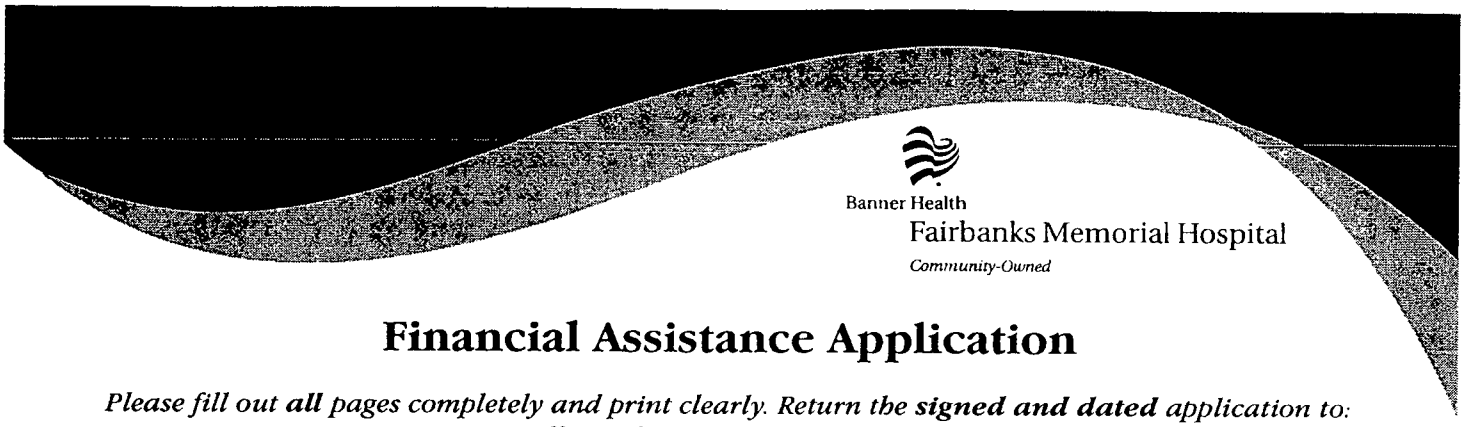

Financial Assistance Application

*Please fill out **all** pages completely and print clearly. Return the **signed and dated** application to:*
FMH Business Office, 1650 Cowles Street, Fairbanks, AK 99701

Patient Information

Assistance Requested By _____ Marital Status _____ Age _____ Date _____

Patient Name _____ Social Security # _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Employer _____ Occupation _____

Employer Phone _____ Length of Employment _____ Gross Salary per Month $ _____ Gross Salary per Year $ _____

Spouse Information

Spouse Name _____ Social Security # _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ Marital Status _____ Age _____

Employer _____ Occupation _____

Employer Phone _____ Length of Employment _____ Gross Salary per Month $ _____ Gross Salary per Year $ _____

Household Information

Please list all household members (include yourself)

Name	Relationship	Age	Income	Dependant
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Banner Health
Fairbanks Memorial Hospital
Community-Owned

Financial Assistance Application

*Please fill out **all** pages completely and print clearly. Return the **signed and dated** application to:*
FMH Business Office, 1650 Cowles Street, Fairbanks, AK 99701

Financial Information

Income sources	Monthly	Yearly
Gross Salary	$	$
Social Security Income	$	$
Food Stamps	$	$
Unemployment Compensation	$	$
Workers Compensation	$	$
Child Support	$	$
Veterans Assistance	$	$
Pensions	$	$
Income from Dividends, Interest	$	$
Scholarships, Grants, Student Loans	$	$
Public Assistance	$	$
Permanent Fund Dividend	$	$
Other Income	$	$
Total Income	$	$

Monthly Rent or House Payment: $_____

☐ Own ☐ Rent ☐ Other, please explain_____

Year and model of car(s) _____
List Monthly payment
Enter 0 if no payment _____

Assets	Balance of Account
Checking	$
Savings or Certificate	$
Trust Fund	$
401K Plan	$
Stocks & Bonds	$
IRA	$
Residence Market Value	$
Insurance Cash Value	$

Other Assets: Describe (rental property, recreational vehicles, etc.)

_____

_____

Total Assets $ _____

I, _____ , hereby request that Fairbanks Memorial Hospital make a determination of my eligibility for financial assistance. I understand that:

- My application will be reviewed for final determination only after all other possible payment resources have been considered (such as Medicaid, Denali KidCare, Veterans Assistance, Indian Health Services, Victims of Violent Crimes or Social Security Income) which may assist me in support of medical expenses.
- I am required to report all income received, including gross taxable and non-taxable income which supports annual income. I further understand that all disclosed income will be considered for determination of Financial Assistance and will not be released without proper consent.
- Financial assistance can only be applied to FMH accounts.
- All of the information which I have provided to FMH for myself and on behalf of my family is true and correct to the best of my ability. I further understand that if any of the information is found to be false, my Financial Assistance application may be denied.

☐ Check this box if you were **not** required to file Federal Income Tax Returns and supporting documentation has been provided.

Signature/Date _____ Signature/Date _____

Do not write below. To be filled out by hospital personnel only.

Additional comments_____

_____

☐ Approved ☐ Denied Processing Clerk_____

Qualifying Gross Income: $_____ # in H/H _____ FPL % _____

Authorization Signature_____ Authorization Name/Title/Date _____