Patient's Name: ____________________

Date: _____________________________

Dear ______________________________

Your application for Bayhealth Medical Center Financial Assistance Program is enclosed. Please complete the following items:

Step 1 **Complete both sides of the Financial Application Form.**

Step 2 **Get proof of your income. We require proof of income for a (4) week period ending with the date of your application. This must include income for all dependent members of the family. You may use a payroll check stub, a letter from the employer, a copy of your monthly check you may receive from the government (for example: alimony, child support, unemployment or social security). We will also need copies of your bank statement for the last (3) months and last years Federal and State Tax Return. Patient's who are retired or on disability we require your Current Social Security Benefit notice and your current SSA-1099 Social Security Benefit Statement from Social Security.**

Step 3 **When steps 1 and 2 are completed you can either mail the application or call to set up an appointment to have your application reviewed by either one of our Financial Counselors, their addresses and telephone numbers are as follows:**

Kent Campus
Attn: Financial Counselor
640 S. State Street
Dover, Delaware 19901

(302) 744 - 7481

Sussex Campus
Attn: Financial Counselor
100 Wellness Way
Milford, Delaware 19963

(302) 430 - 5727

In order for your application to be considered it must be completed, dated, signed and return to the hospital within (30) days of being sent to you.

Sincerely,

Financial Counselor

SURGERY PATIENTS

If you are scheduled, or being scheduled, for surgery it is important you advise us now and do your best to complete and return the application in its entirety to us as soon as possible prior to your surgery.

Surgery Date: ____________________________

Physician Name: ___________________________

Physician Phone Number:____________________

P10195 (7/13)

Patient Label

FINANCIAL APPLICATION

Date__________________ SS#______________________________

Patient's Name____ Date of Birth_____________________

Home Address ____ Phone__________________

Patient's Employer____Phone__________________

If Unemployed: How long Unemployed________ Former Employer__________________________

Date Became Unemployed__________________ Are you eligible for COBRA_____________________

Employer's Address____

(If Self Employed Provide Business Address)

Occupation____How long Employed__________

To be Completed by Full Time Students Only:

Are you covered under your parent's, or another insurance policy through the university? _________

If yes, provide policy information:____

Are your parents claiming you as a dependent on their taxes? _____Yes _____No

Residence Location: _____ On Campus Housing _____Off Campus Housing

Responsible Party Name_______________________ SS#__________________ Date of Birth____________

Responsible Party Address____ Phone___________________

Spouse's Employer____Phone__________________

Spouse's Name_______________________________SS#___________________ Date of Birth_____________

Spouse's Employer Address____ Phone__________________

Spouse's Occupation____ How long Employed_____________

Total Monthly Gross Income________________________ Total Monthly Net Income___________________

All Other Income _____________________(Spouse emp., Alimony, Child Support, etc.)

No. of Dependents ________ (under 18 or 21 if full time student)

Name(s) of Dependents ____

FINANCIAL INFORMATION

Bank___________________________________City__________________State________________________

Own Home_____ Buying _____ Approx. Value ____________ Rent _________ How Long______________

Other Property__________________________ ___________________Approx. Value __________________

Mortgage Holder/Landlords Name & Address____

Auto #1 __________ Make __________ Year __________Financed by ___________________________

Auto #2 __________ Make __________ Year __________Financed by____________________________

Recreational Vehicles Own: ________Boat, Motorcycle, Camper, etc.________________________________

FINANCIAL APPLICATION

Patient Label

Office Use Only

Acct. # _______________ Amt. ____________O/I Acct. # ________________Amt. ____________ O/I
Acct. # _______________ Amt. ____________O/I Acct. # ________________Amt. ____________ O/I
Acct. # _______________ Amt. ____________O/I Acct. # ________________Amt. ____________ O/I
Acct. # _______________ Amt. ____________O/I Acct. # ________________Amt. ____________ O/I
Acct. # _______________ Amt. ____________O/I Acct. # ________________Amt. ____________ O/I

List all debts owed in order excluding Bayhealth's debt

	To Whom Indebted Name of Company	Type of Acct.	Current Balance	Account Number	Monthly Payment
Mortgage					
Auto #1 ____________					
Auto #2					
Credit ____________ Cards					
Banks Finance____________ Co. Etc.					
Medical____________ Bills					
Other					

MONTHLY HOUSEHOLD EXPENSES

Food _______ Elec. _______ Gas _______ Sanitation _______ Phone _______Water _______Cable ______
Child Care ________Auto Ins. _______________

CREDIT INVESTIGATION AUTHORIZATION

I hereby authorize Bayhealth Medical Center or it's agent to investigate any references, statements, or other data made by me or any other person pertaining to my credit and financial responsibility. I affirm that the information given on my Financial Application Form is true and correct.

Signature_____________________________________ Date __________________

OFFICE USE ONLY

Date Application Received__________________________________ Eligible Charges___________________

Comments:

Physician Office Response for Surgery: Urgent______ Semi-Elective______ Elective______