

**Exhibit C  
Financial Assistance Form**



Charity Care/Financial Assistance Program Application

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Patient Account Number: \_\_\_\_\_ Date of Application \_\_\_\_\_

**PATIENT INFORMATION**

**PARENT/GUARANTOR/SPOUSE**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

State/Zip \_\_\_\_\_

SS# \_\_\_\_\_

SS# \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

State/Zip \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Length of Employment \_\_\_\_\_

Length of Employment \_\_\_\_\_

Supervisor \_\_\_\_\_

Supervisor \_\_\_\_\_

**RESOURCES**

Checking:    yes\_\_\_       no\_\_\_       Vehicle 1: Yr\_\_\_\_\_ Make\_\_\_\_\_ Model\_\_\_\_\_

Savings:     yes\_\_\_       no\_\_\_       Vehicle 2: Yr\_\_\_\_\_ Make\_\_\_\_\_ Model\_\_\_\_\_

Vehicle 3: Yr\_\_\_\_\_ Make\_\_\_\_\_ Model\_\_\_\_\_

Cash on hand: \$ \_\_\_\_\_

