Freeman NHSC Assistance Application

ADMISSIONS/PATIENT ACCOUNTS USE ONLY

☐ Approved 100%	Account #: _____
☐ Approved sliding applicant owes Co-pay Tier I ☐ Approved sliding applicant owes Co-pay Tier II	Physician: _____
☐ Denied due to:	Date submitted: _____

APPLICANT/PATIENT INFORMATION

Patient Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Message phone: _____ Driver's license #: _____

Parent/ Guardian Name: _____

Parent/ Guardian Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Message phone: _____ Driver's license #: _____

HOUSEHOLD SIZE

Name	Date of Birth	Age	Name	Date of Birth	Age
SELF			DEPENDENT		
SPOUSE			DEPENDENT		
DEPENDENT			DEPENDENT		
DEPENDENT			DEPENDENT		

HOUSEHOLD EMPLOYMENT/ ANNUAL INCOME INFORMATION

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, annuity, veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment and dependents				
Rent, interest, dividend, unemployment, and other income				

APPLICANT ACKNOWLEDGEMENT

I understand the information I have given is subject to verification and review by Freeman. Should I receive or have any income not listed, I understand that my approval for financial assistance can be denied, and I will then be responsible for paying my account. I certify the information provided is true and correct, under penalty of perjury. *Marital status is optional and not required for consideration of this program.

Applicant signature: _____ Date: _____

Approved by: _____ Date: _____