Digestive Care Center

801 St. Mary's Drive, Suite 205 W
Evansville, IN 47714
PH: 812-477-6103

Office Use Only:

_____

Date Sent: _____

Financial Assistance Application

Please complete the application to the best of your ability and as fully as possible. This will help us answer your request as quickly as possible. If you would like to provide additional information that you feel will help us better understand your situation, please attach a letter to this application.

You must provide proof of gross household income. This may be in the following forms:

- Last three pay stubs
- Last year tax return
- Other documentation indicating your year-to-date income.

Patient Information:

Patient Name:	Birth Date:	Marital Status:	Telephone Number:
Address:			Zip:
Social Security Number:	Employer:	Full Time or Part Time:	How many hours per week?
Employer Address:			Employer Phone:

Responsible Party Information:

Patient Name:	Birth Date:	Marital Status:	Telephone Number:
Address:			Zip:
Social Security Number:	Employer:	Full Time or Part Time:	How many hours per week?
Employer Address:			Employer Phone:

Responsible Party Spouse Information:

Patient Name:	Birth Date:	Marital Status:	Telephone Number:
Address:			Zip:
Social Security Number:	Employer:	Full Time or Part Time:	How many hours per week?
Employer Address:			Employer Phone:

Dependents - (Anyone living in the household):

Name:	**Age:**	**Relation:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Proof of Income:

Applicant:	**$**	Work Comp:	**$**
Applicant Spouse:	**$**	Child Support:	**$**
Social Security:	**$**	Food Stamps:	**$**
VA Pension:	**$**	Other:	**$**
Pension:	**$**	Other:	**$**
Unemployment:	**$**	**Total:**	**$**

Assets:

Cash on Hand:	**$**	Vehicle Make:	
Savings Account:	**$**	Vehicle Year:	
Checking Account:	**$**		
Home Value:	**$**		
Total:	**$**		

Debts:

Home Loan Balance:	**$**
Car Loan Balance:	**$**
Credit Card Balances: (list below)	
1.	**$**
2.	**$**
3.	**$**
4.	**$**
Other debts:	**$**
Other debts:	**$**
Other debts:	**$**
Total:	**$**

Monthly Payments:

Mortgage:		Child Support:	
Rent:		Daycare:	
Electric:		Clothing:	
Gas:		Food:	
Telephone/Internet/Cable:		Credit Cards: (list below)	
Cell Phone:		1.	
Car Payment:		2.	
Daycare:		3.	
Auto Insurance:		Medical Insurance:	
Property Insurance:			

Total Monthly Payments: $_____

Comments:

_____
_____
_____
_____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the physician practice to obtain information from external credit reporting agencies if the physician practice deems necessary.

_____ _____

Signature of Patient, Spouse, Guarantor or Legal Representative **Date**