BETHESDA HEALTH

Financial Assistance Application

Date: _____ Account Number: _____

Patient's Name: _____
Last First MI

Date of Birth: _____ Social Security Number: _____

Home Address: _____
Street City State Zip Code

Home Phone #: _____ Cell #: _____ Work #: _____

Name of Responsible Party: _____ Relationship: _____

Home Address: _____
Street City State Zip Code

Employer: _____ Position: _____ Years: _____

Employer Address: _____ Phone #: _____

Number living in household: _____

Your Monthly Income: $ _____ Spouse Monthly Income: $ _____

All Other Household Income: $ _____ Copy of W-2s

Mortgage / Rent: $ _____ Utilities: $ _____

Outstanding Expenses, Including Hospital Bills: $ _____

Credit Cards (Mastercard, Visa, American Express, Others): _____

Applicant's Certification:

THE UNDERSIGNED HEREBY CERTIFIES THAT THE INFORMATION RECORDED IN THIS CHARITY APPLICATION IS TO BE TRUE AND CORRECT TO THE BEST OF THEIR KNOWLEDGE AND THAT THERE ARE NO KNOWN ITEMS, EITHER INCLUDED OR EXCLUDED THAT WOULD MATERIALLY CHANGE THE RESULTS.

_____
Signature Date/Time

_____
Witness to Signature Date/Time

Interpreted By: _____
Date/Time

Bethesda Hospital East 2815 S. Seacrest Blvd Boynton Beach, FL 33435 (561) 737-7733
Bethesda Hospital West 9655 Boynton Beach Blvd Boynton Beach, FL 33472 (561) 336-7000

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