HALIFAX REGIONAL MEDICAL CENTER
APPLICATION FOR MEDICAL FINANCIAL ASSISTANCE

Date of Request _____ Application Completed by _____

I hereby request that Halifax Regional Medical Center determine my eligibility for uncompensated hospital services. I understand that the information which I submit concerning my income and family size is subject to verification by Halifax Regional Medical Center. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services and that I will be liable for charges for services provided.

1. Name: _____
   First Middle Last

2. Address:_____
   Number and Street City State Zip Code

   Telephone Number: _____
   Occupation: _____
   Employer's Name and Address: _____

3. List Family Members (include age of each child)

Name: _____Age____	Name: _____Age ____
Name: _____Age____	Name: _____Age ____
Name: _____Age ____	Name: _____Age ____

4. Income: List income for family from:

	Total Last 12 Months
Wages……	_____
Farm (proprietary Interest) or self-employment……	_____
Public Assistance……	_____
Social Security……	_____
Unemployment Compensation……	_____
Workers Compensation……	_____
Alimony/Child Support……	_____
Pensions……	_____
Income from Dividends, Interest, Rent……	_____
Others (specify)……	_____
Total……	_____

5. List date of service to be covered by this application: _____
   I affirm that the above information is true and correct to the best of my knowledge.

_____ _____
Date Patient's Signature