Application
Smoky Valley Cares Fund

PATIENT INFORMATION:

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY/STATE/ZIP _____

PHONE _____

NAME OF PRIMARY CARE PHYSICIAN _____

APPLICANT/CONTACT PERSON IF DIFFERENT FROM THE PATIENT:

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ CITY/STATE/ZIP _____

PHONE _____

FINANCIAL INFORMATION

Number of people currently living in the household **over** 18 years of age _____

Number of people currently living in the household **under** 18 years of age _____

Current income (estimate) _____ (per month/per year)

Other household income (estimate) _____ (per month/per year)

To protect patient privacy, no financial or diagnostic information will be revealed beyond the "need to know" employees that process the application.

TO QUALIFY FOR ELIGIBILITY

Please deliver a copy of your prior year Federal Income Tax Form or three most recent months of employer pay receipts for all household members to Financial Services. Additional documentation may be required to substantiate financial assistance eligibility.

ACKNOWLEDGEMENT

I hereby certify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature of applicant date