BENSON HOSPITAL- PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

Benson Hospital recognizes that certain patients may require financial assistance in paying for health care services. The Patient Financial Assistance Program has been designed by the hospital in response to the needs of these patients.

Attached is the Patient Financial Assistance Application for you to complete and return to us. The information requested on the form will assist us in determining if you qualify for assistance. Please fill out the attached form as completely as possible and return with copies of the items that are checked below.

- ❑ **Most current W-2s and tax forms**
- ❑ **Last three (3) paycheck stubs from employment**
- ❑ **Social Security Award Letter for current year**
- ❑ **Unemployment Compensation Benefit Letter**
- ❑ **Copy of Checking/Savings Account Statement(s)**
- ❑ **Rent Receipt/Lease/Mortgage Statement**
- ❑ **Room and Board/Support Letter**
- ❑ **Utility Bills**
- ❑ **Divorce Decree**

An incomplete application will be denied until it is fully completed.

If you have any questions regarding the financial application or documents needed, please contact the Business Office at (520)586-1873 or by E-Mail at FAP@bensonhospital.org.

BENSON HOSPITAL BUSINESS

OFFICE Enc.: Application

BENSON HOSPITAL - PATIENT FINANCIAL ASSISTANCE PROGRAM
APPLICATION

PATIENT'S NAME			SEX	PATIENT ACCOUNT NUMBER	
GUARANTOR'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY #
ADDRESS OR PO BOX		CITY	STATE	ZIP	PHONE
SPOUSE'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY #
ADDRESS OR PO BOX		CITY	STATE	ZIP	PHONE
# IN HOUSEHOLD				PATIENT LIVES IN HOUSEHOLD	YES 0 NO ❑
# OF CHILDREN UNDER 18 IN THE HOUSEHOLD				# OF DEPENDENT CHILDREN OVER 18	
# OF DEPENDENT CHILDREN OVER 18 THAT ARE FULL-TIME STUDENTS				# OF DEPENDENT CHILDREN THAT ARE DISABLED	
	HOME OWN RENT		L_1 ❑	HOW LONG AT PRESENT ADDRESS	

MONTHLY INCOME SOURCES	SPOUSE #1	SPOUSE 42	CHILDREN	TOTAL
Employment				
Social Security				
Industrial Comp				
Unemployment				
Penslon/Retirement/Annuities				
ADC,GA,Food Stamps				
Other (rental income, child support, spousal, etc.)				
TOTAL GROSS INCOME				

MONTHLY EXPENSES

HOME (RENT/MORTGAGE)	CAR		CAR
ELECTRIC BILL	GAS BILL		WATER BILL
PHONE BILL	TRASH BILL		CABLE BILL
CELL PHONE BILL	GROCERY		OTHER
CHECKING. Circle One YES NO	5 TOTAL AMOUNT		BANK NAME
SAVING. Circle One YES NO	S TOTAL AMOUNT		BANK NAME

I CERTIFY THAT THE INFORMATION GIVEN HEREIN IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DELIBERATE FALSIFICATION CAN LEAD TO DENIAL OF CONSIDERATION. I HEREBY AUTHORIZE THE HOSPITAL TO MAKE ANY NECESSARY INQUIRIES TO VERIFY AND TO OBTAIN ANY ADDITIONAL INFORMATION REQUIRED BY THE FACILITY,

GUARANTOR SIGNATURE		DATE
SPOUSE SIGNATURE		DATE

- RELATIONSHIP OF HOUSEHOLD MEMBERS: Divorce Decree or Copy of Death CertIfIcal
- PROOF OF RESIDENCY: Rent Receipt/Lease/Mortgage Statement or Room and Board/Support Letter;UtIlity Bills
- ASSETS: Bank and credit union statements for the last three (3) months
- INCOME FOR ALL HOUSEHOLD MEMBERS: Last three (3) paycheck stubs/employer's statement listing gross wages, Social Security Award Letter for current year or Unemployment Compensation Benefit Letter
- Most current W-2's and tax forms