Trego County Lemke Memorial Hospital
WaKeeney Family Care Center   Ellis Family Care Center
FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: ______________________________ DATE: ______________________

PLEASE INDICATE MARITAL STATUS: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed
YOUR RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent ☐ Step Parent ☐ Other

YOUR NAME:______________________ SPOUSE NAME:______________________

ADDRESS: ______________________________ HOW LONG: ______________

HOME PHONE: ______________________ CELL PHONE: ______________________

SOCIAL SECURITY NO: ______________ SPOUSE SOCIAL SECURITY NO: ______________

NUMBER OF PERSONS, INCLUDING YOURSELF, DEPENDANT ON YOU FOR MORE THAN HALF THEIR SUPPORT: ________

PLEASE LIST CHILDREN'S NAMES AND AGES: ______________ AGE:_____ ______________ AGE: _____

______________ AGE: _____ ______________ AGE: _____

NEAREST RELATIVES NOT LIVING WITH YOU:

NAME	ADDRESS	RELATIONSHIP	PHONE #

EMPLOYER: ______________________ SPOUSE EMPLOYER: ______________________

EMPLOYER PHONE: ______________________ SPOUSE EMPLOYER PHONE: ______________________

MONTHLY INCOME: $ ______________ DO YOU ☐Own ☐Rent Your Home ☐Other ______________

PLEASE LIST OTHER ASSETS/INCOME: ______________ $______________ ☐Monthly ☐Weekly

______________ $______________ ☐Monthly ☐Weekly

AUTOMOBILE: YEAR ________ MAKE________ MODEL________ VALUE $________PAYMENTS $________

YEAR ________ MAKE ________ MODEL________ VALUE $________PAYMENTS $________

BANK INFORMATION: ______________________________ ☐ Checking ☐ Savings

PLEASE LIST ALL PRESENT INDEBTEDNESS, FINANCIAL INSTITUTIONS, MERCHANTS, CREDIT CARD DEBT, INDIVIDUALS OR OTHER MEDICAL PROVIDERS WITH WHOM YOU NOW HAVE OR HAVE HAD CREDIT DEALINGS: (You May Use Additional Sheets, if necessary)

MORTGAGE/RENT PAYMENT: $______________________ TOTAL UTILITIES: $______________________

PLEASE ATTACH A SEPARATE SHEET LISTING ANY OTHER CREDITORS YOU MAY OWE WITH FOLLOWING INFORMATION: Name of Creditor, Address, Unpaid Balance, Payment and Past Due Amount

PLEASE ATTACH A COPY OF LAST YEAR'S INCOME TAX RETURN
ATTACH PAY STUBS AND A BUDGET SHOWING DISPOSABLE INCOME LESS MONTHLY EXPENSES (PLEASE LIST)
FEEL FREE TO INCLUDE ANY OTHER INFORMATION ABOUT YOUR SITUATION THAT SHOULD BE CONSIDERED.

PLEASE RETURN THIS FORM AND ALL REQUESTED DOCUMENST NO LATER THAN FIVE DAYS FROM RECEIPT.
I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THAT NO UNFAVORABLE INFORMATION KNOWN TO ME HAS BEEN OMITTED.

______________________________ ______________________________
SIGNATURE SIGNATURE

NAME: ____________________

ASSETS

		Value
Vehicle Model/Year		$
Vehicle Model/Year		$
Bank Name		Balance
Address		$
Bank Name		Balance
Address		$
Real Estate		Market Value
Other Assets (Description)		Value
		$
		$
		$

MONTHLY INCOME

Patient's Earnings	Gross Income	$
	FICA & Income Tax	$-
	Net Income	$
Spouse's Earnings	Gross Income	$
	FICA & Income Tax	$-
	Net Income	$
Child Support/Alimony Received		$
Interest/Dividends		$
Rents/Royalties		$
Social Security		$
Pension/Annuity/Disability		$
Other (List)		$
TOTAL MONTHLY INCOME		

MONTHLY EXPENSES

Rent/Mortgage	$
Gas/Electric/Water	$
Telephone	$
Child Support	$
Child Care	$
Food/Groceries	$
Medications	$
Auto (Gas/Repairs)	$
Insurance - Health	$
Life/Disability	$
Auto	$
Homeowner's	$
School Expenses	$

	Balance	Lendor/Creditor	Monthly Payment
Auto Loan	$		$
Home Loan	$		$
Other Loans	$		$
	$		$
	$		$
Medical Bills	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
Credit Cards	$		$
	$		$
	$		$
TOTAL MONTHLY EXPENSES			

Please submit application and all supporting documents to the business office or email to CAdams-Cleland@tclmh.org