Financial Assistance Application (FAA)

Craig Hospital

Application for Charity Care and Self Pay Discounts

Please complete all sections. Do not leave blanks. Mark N/A if not applicable. Missing information will delay application approval process.

Patient Name ________________________________ Account Number (if known)______________________

Patient Social Security Number _____________________ Primary Phone Number _________________________

Patient Date of Birth (Month, Day, Year) ___________________________ Age _______

Patient Address (Street, City, State, Zip Code) ____

Employer (Name, Address and Phone Number) ____

____

Spouse Name (or Parent(s) if Patient is a Minor) ____

Spouse/Parent Social Security Number __________________________________

Spouse/Parent Employer (Name, Address and Phone Number) __________________________________

____

Household Income (Post Injury): Please provide the gross income for each of the following persons in your household:

Patient $ ___________ / Year

Patient's Spouse $ ___________ / Year

Parent (s) (if patient is a minor) $ ___________ / Year

Other income $ ___________ / Year

Total Income $ ___________ / Year

Family Size*:* Please provide the number of people in the patient's household: ____________

Income Verification*:* Please provide one or more of the following types of documentation to verify your income:

Paycheck stub
Most recent IRS Form W-2
Most recent Income Tax Return
Signed attestation to income
Bank statements

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

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Liquid Assets and Other Resources: Please list the following types of accounts including current balances:

Savings and money market accounts $___________
Health savings accounts (including flex spending, health savings account) $__________
Investments $__________
Trust funds $__________
Retirement accounts $__________

Additional information or comments:
Please list any additional information that should be considered in the application or use this space to further explain the information provided above.

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____
____
____
____

Attestation statement:
By providing the information above, I understand that Craig Hospital may verify the information contained in this application. I certify that the statements made in this application are true and correct to the best of my knowledge and are made in good faith. I also understand that this application is for financial assistance related to medical services billed by Craig Hospital and does not include charges related to physician services.

______________________________ ______________________________

Signature of Patient/Responsible Party/ Person Completing Application | Date

____

Printed Name of Patient/Responsible Party/ Person Completing Application

Internal Use Only

Person Reviewing Application: ______________________________

Comments ______________________________
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____

Category: ☐ Traditional ☐ Medically Indigent ☐ Presumptive

Person Approving Application ______________________________ Amount ______________

______________________________ ______________________________
Signature of Approver | Date