

Household Income: Total/Monthly: Total/Yearly:
Wages _____ \$ _____ \$ _____
Other _____ \$ _____ \$ _____

Do you have a checking account? Yes _____ No _____
Do you have a savings account? Yes _____ No _____

If financial assistance is received from an outside source, a notarized statement, including the amount and type of assistance provided, should accompany this application.

Admitting Diagnosis _____

Public Assistance

Have you ever applied for Medicare or other public assistance? _____

What was the approximate date of your application? _____

What response have you received? _____

I hereby request that my application for Financial Counseling Services be reviewed by the East Alabama Medical Center Financial Counseling Services Committee. I understand that the information submitted herein is subject to verification by EAMC. I also understand that if the information that I have submitted is determined to be false, it will constitute fraud. Such a determination will result in a denial of Financial Counseling Services, and I will be liable for charges for services provided.

Signature (EAMC Representative)

Signature (Patient)

Date

Signature (Applicant)

Additional Comments:

