



HALIFAX REGIONAL MEDICAL CENTER
APPLICATION FOR MEDICAL FINANCIAL ASSISTANCE

Date of Request Application Completed by

I hereby request that Halifax Regional Medical Center determine my eligibility for uncompensated hospital services. I understand that the information which I submit concerning my income and family size is subject to verification by Halifax Regional Medical Center. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services and that I will be liable for charges for services provided.

1. Name: First Middle Last

2. Address: Number and Street City State Zip Code

Telephone Number:
Occupation:
Employer's Name and Address:

3. List Family Members (include age of each child)

Table with 4 columns: Name, Age, Name, Age. Three rows for family members.

4. Income: List income for family from:

Total Last 12 Months

Table with 2 columns: Income Source, Total. Rows include Wages, Farm, Public Assistance, Social Security, Unemployment Compensation, Workers Compensation, Alimony/Child Support, Pensions, Income from Dividends, Interest, Rent, Others, and Total.

5. List date of service to be covered by this application:

I affirm that the above information is true and correct to the best of my knowledge.

Date

Patient's Signature