## ST. MARY'S MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION

Patient's Last Name	t's Last Name Patient's First Name		iddle Initial	Date of Application		n Patient Ac	count No.	Patient's Date of Birth
Patient's Home Address		Patient's City				Patient's State		Patient's Zip Code
Social Security No.	curity No. Home Phone Num		Work Phone	none Number Name		of Guarantor		Relationship to Patient
<b>Guarantor's Address</b>		Guaran	itor's City			Guarantor's	State	Guarantor's Zip Code
Guarantor's Employer G		uarantor's Employer Address				Guarantor's Employer Phone No.		
Name of Dependent(s) Living 1.	ng With You		Inc	ome	]	Relationship		Age
2.								
3.								
4.								
5.								
6.								
Total Number of Qualifying Dependents:								
Yearly Wage Calculation:								
Guarantor Signature:			D	Pate:				
****FOR OFFICE USE OF								
Financial Counselor Signa								
Approved by: % Amount Approved						<b>Date:</b>		