Financial Aid Application

Patient and/or Guarantor information if patient is a minor:

Name:_____________________________________ Date of Birth:__________________

Address:____ City:____________________

State:________ Zip:____________________ Phone: (_____) ________________________

Social Security #:____________________________ Marital Status:__________________

Employer:____________________________ Position:_____________________________

Annual Salary:____________ Length of Employment:_____________________________

Health Insurance Company:__________________________ Policy #:________________

Spouse and/or Legal Guardian Information:

Name:_______________________________ Date of Birth:_________________________

Employer:______________________ Social Security #:___________________________

Annual Salary:__________________ Position:___________________________________

Dependent (s) Information:

Number of Dependents:_________________

Name:_______________________________ Relationship:_________________________

Name:_______________________________ Relationship:_________________________

Name:_______________________________ Relationship:_________________________

Use a separate sheet of paper if necessary:

Asset Information Please write yes or no:

Automobile:________ Rental Property:__________ Farms:______ Cattle:______

Do you own a business:___________ Name of business?__________________________

Checking Account:____________________ Bank Name:_________________________

Balance: $________________

Savings Account:______________________ Bank Name:_________________________

Balance: $________________

Disclaimer and Authorization:
I authorize Simpson General Hospital to obtain a consumer credit report on my behalf to process my application if necessary. This information will only be used for the purpose it was intended. I also understand that Simpson General Hospital will not share or disclose the information with any third party vendor unless I give the proper authorization. Simpson General Hospital will not give me a copy of my credit report; it will stay in the hospital financial record. I also authorize Simpson General Hospital to verify all the information given by me to process my application.

Applicant's Name ______________________

Applicant's Signature __________________ Date: _____________