Serving All of Gem County
1202 E Locust St Emmett, Idaho 83617
Phone (208) 365-3561 Fax (208) 365-4176

Financial Assistance Application

Responsible Party Name: ____ Marital Status: S M D W (circle one)

Address: ____ City: ____________________ State: _____ Zip: __________

SS#: ________ - ________ - _________ Date of Birth: ________________ Telephone: ___________________________

Employer: _______________________________________ Telephone: _________________ Date of Hire: _______________

Address: ____ City: ____________________ State: _____ Zip: __________

Spouse's Name: __________________________________ SS#: _______-_______-______ Date of Birth: _______________

Spouse's Employer: _______________________________ Telephone: ___________________ Date of Hire: _______________

Number of Dependents at Home: ___________________ Their Ages: _______ _______ _______ _______ _______

List Account Information for Members in Household: (Attach a separate sheet if necessary)

Patient Name:	**Account #**	**Balance:**	**Age:**	**Relationship:**

Date approved: _______________________________ Approved by: ____

Date denied: _________________________________ Reason for denial: ____

"Our Priority is People"

MONTHLY INCOME INFORMATION

Incomes Sources: W-2 form, income tax statement, check stubs, or check statements may be required for verification.
If self-employed, a financial statement may be required.

Source of Income	Responsible Party	Spouse
Wages (before Deductions)........................	$ _______________	$ _______________
Alimony	$ _______________	$ _______________
Child Support / Adult Support	$ _______________	$ _______________
Disability/Worker's Compensation	$ _______________	$ _______________
Pension	$ _______________	$ _______________
Social Security Income	$ _______________	$ _______________
Dividends/Interest/Income	$ _______________	$ _______________
Rental Income	$ _______________	$ _______________
Estate/Trust Income	$ _______________	$ _______________
Other	$ _______________	$ _______________
Less FICA/State/Federal Taxes	$ _______________	$ _______________
Less Any Other Deductions	$ _______________	$ _______________
MONTHLY INCOME TOTALS:	$ _______________	$ _______________

Ever filed Backruptcy? (circle one) NO YES If yes, what year? ___________

MONTHLY PAYMENTS

ALL REAL PROPERTY/VEHICLES	Balance	Monthly Payment
Residence: (Circle one) Own Rent	$ _______________	$ _______________
Other Real Property (List) ___________________________	$ _______________	$ _______________
Vehicle #1: Make ______________ Model _____________ Year __________	$ _______________	$ _______________
Vehicle #2: Make ______________ Model _____________ Year __________	$ _______________	$ _______________
Recreation Vehicle: _________________________________ Model ___________________ Year ____________	$ _______________	$ _______________
Other Vehicle: _____________________________________ Model ___________________ Year ____________	$ _______________	$ _______________
Subtotal:	$ _______________	$ _______________

MONTHLY PAYMENTS CONTINUED

(List Creditor Name - Attach List If Necessary)	Balance	Monthly Payment
Credit Card: ________________________________	$ ______________	$ ______________
Credit Card: ________________________________	$ ______________	$ ______________
Credit Card: ________________________________	$ ______________	$ ______________
Student Loan: _______________________________	$ ______________	$ ______________
Student Loan: _______________________________	$ ______________	$ ______________
Other Loans/Creditors__________________________	$ ______________	$ ______________
Other Loans/Creditors ____________________________	$ ______________	$ ______________
Subtotal:	$ ______________	$ ______________

OTHER MONTHLY EXPENSES

Food	$ ______________	$ ______________
Auto Insurance	$ ______________	$ ______________
Fuel (Gasoline)& Auto Maintenance	$ ______________	$ ______________
Health Insurance . . . . (If not deducted from payroll)	$ ______________	$ ______________
Presciptions	$ ______________	$ ______________
Utilities:		
Heating Fuel	$ ______________	$ ______________
Home Telephone	$ ______________	$ ______________
Cell Phone	$ ______________	$ ______________
water/Sewer/Trash	$ ______________	$ ______________
Electric	$ ______________	$ ______________
Cable TV	$ ______________	$ ______________
Internet	$ ______________	$ ______________
Life Insurance	$ ______________	$ ______________
Renter/Homeowners Insurance	$ ______________	$ ______________
Child Support and/or Daycare	$ ______________	$ ______________

Clothing . . . . $ ______________ $ ______________

Charitable Contributions . . . . $ ______________ $ ______________

OTHER MONTHLY EXPENSES CONTINUED

Other (List) ______________________________________ $ ______________ $ ______________

Subtotal: $ ______________ $ ______________

MEDICAL EXPENSES:	Balance	Monthly Payment
Hospital/Physician/Clinic Name _____________________	$ ______________	$ ______________
Hospital/Physician/Clinic Name _____________________	$ ______________	$ ______________
Hospital/Physician/Clinic Name _____________________	$ ______________	$ ______________
Subtotal:	$ ______________	$ ______________

MONTHLY FINANCIAL SUMMARY:

Monthy Income Total (Page 2)	$ ______________	
Monthly Payments (Real Property/Vehicles-Page 2)		$ ______________
Monthly Payments (Creditors - Page 3)		$ ______________
Other Monthly Expense Payments (Page 4)		$ ______________
Monthly Medical Expense Payments (Page 4)		$ ______________
TOTAL MONTHLY EXPENSES		$ ______________

If expenses are more than the income listed, please describe how expenses are met each month:

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I hereby state the information I have provided is true and complete. I authorize Valor Health to verify this information including requesting a Credit Bureau Report when necessary. I understand that if any of this information is determined to be deceptive or false, I may be denied financial consideration and I will be liable for any and all charges incurred for services rendered. All information must be submitted by the patient within 30 days of the receipt of this application.

( ) ____ ________________________

Responsible Party's Signature Date