Compassionate Care Application

Patient's Personal Information

Medical Record Number: _____

Name: _____

Address: _____

Telephone: Home ( ) _____ Work ( ) _____

Marital Status: _____ Date of Birth: _____

Spouse/Legal Guardian's Name: _____

APPLICANT'S INFORMATION (If other than patient):

Name: _____ Relation to patient: _____

Address: _____

Telephone: Home ( ) _____ Work ( ) _____

Patient	Spouse
Employer: _____	_____
Occupation: _____	_____

If you are presently unable to work due to medical conditions, when will you return to work? _____

Have you applied for Medicaid? _____ SSI? _____

If YES, state your Medicaid/SSI case worker's name: _____

Medicare # _____ Effective Date _____

Medicaid # _____ Effective Date _____

NOTE: If you were denied for Medicaid or SSI, attach denial letter to this application.

Dependents (as defined by IRS rules):

NAME	RELATION	AGE
1,		
2,		
3,		
4,		
5,		

Financial Statement

Income (Household)	Monthly Amount	Expenses	Monthly Amount
Salary, Wages	_____	Rent/Mortgage	_____
Social Security	_____	Credit Cards	_____
Other Retirement Income	_____	Telephone	_____
Disability	_____	Electric & Gas	_____
AFDC	_____	Water	_____
Food Stamps	_____	Auto Payment	_____
Unemployment Income	_____	Other (describe)	_____
Veteran's Benefits	_____		
Investment Income	_____		
Rental Income	_____		
Other Income (describe)	_____		
Total Monthly Income	_____	**Total Monthly Expense**	_____

Note: Attached documentation must support information provided.

Please attach the following to the application:

- ☒ Last 3 months' bank statements
- ☒ Most recent signed Federal Income Tax Returns
- ☒ Last 30-60 days year-to-date pay check stub (if you are married, spouse's income documentation required also)
- ☒ If you are retired or disabled, most recent Social Security SAS – 1099 form

I certify that the information on this Application is complete and accurate.

_____ _____

Signature **Date**