ALTRU HEALTH SYSTEM
FINANCIAL ASSISTANCE SCREENING APPLICATION FORM

Fund applying for_____

PATIENT INFORMATION:

Patient Name: _____Date of Birth: _____

Address:_____City:_____

State/Zip:_____ Phone: _____

If you do not have a phone, please give a daytime phone number where you can be reached.
Is it okay to leave a message at this number? Yes_____ No_____

Marital Status: Single / Married / Divorced / Widowed Gender: Male____ Female_____

HOUSEHOLD INFORMATION:

Total household income before taxes for a year _____

OR average monthly income before taxes_____ Number in household _____

INSURANCE INFORMATION:

Do you have any medical insurance? Yes _____ No_____

If yes, Name of Insurance_____

If no; Please contact Altru's HERO program at 780.5060

COMMENTS:

Please comment on any extenuating circumstances which should be reviewed to determine eligibility:

_____
_____
_____
_____

The information above is correct to the best of my knowledge. I understand this form is for screening purposes and that I may be contacted by a financial counselor for more information.

Patient Signature _____ Date: _____