CLIFTON GILLESPIE FUND

APPLICATION FOR ASSISTANCE
HOSPITAL BILL ONLY

DATE: _____

NAME OF PATIENT: _____ DATE OF BIRTH: _____

ADDRESS: STREET_____CITY_____STATE_____

OCCUPATION: _____INCOME: _____LAST 4 DIGITS OF SSN: _____

NUMBER OF DEPENDENTS IN HOUSEHOLD: _____ PHONE #:_____

DO YOU HAVE INSURANCE: NO____YES_____ IF YES MEDICAL INSURANCE CARRIER: _____

MEDICARE: _____VETERANS:_____ OTHER: _____

PARENTS OR SPOUSE: _____OCCUPATION: _____

INCOME: _____PHONE #:_____

MONTHLY EXPENSES:

OWN HOME: _____ RENT: _____ MONTHLY HOUSE PAYMENT OR RENT: $_____

UTILITIES: $_____ INSURANCE: $ _____ CAR: $_____

OTHER EXPENSES OR DEBTS: $_____

TOTAL AMOUNT DUE TO HOSPITAL: $_____

RETURN THIS APPLICATION WITH ITEMIZE COPY OF HOSPITAL BILL.

AUTHORIZATION SIGNATURE TO RELEASE INFORMATION: _____

_____

_____

DATE RECIEVED: _____

ASSISTANCE PROVIDED DATE: _____

REASON DENIED: _____

APPLICATION APPROVED BY: _____