Financial Assistance – Application Form

Name of Patient:	
Patient's Date of Birth:	Patient's Social Security Number:

Address:		
City:		State:
Zip:	Country:	

Daytime Phone:
Alternate Phone:

Requested Services: Check the services for which you are requesting financial assistance.

If you have already received a bill, please give us your account or patient ID number: ________________

Do you have health insurance? ☐ Yes ☐ No

Did you apply for Medical Assistance in the past 6 months? ☐ Yes ☐ No
*If yes, please enclose a copy of the Letter of Denial.

Household Information: List ALL members of your household, including dependents, who were on your most recent IRS Form 1040.

Names	Relation to Patient	Age

Total number of household members (including the patient): ______________

As an attachment to this application, please submit the following:

- Tax returns and supporting schedules (previous 2 years)
- Pay stubs for the most recent 3 months

Certification Signatures

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by the Navajo Health Foundation – Sage Memorial Hospital. I give my permission for the Navajo Health Foundation – Sage Memorial Hospital to investigate the information contained herein.

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Patient or Responsible Party Signature   Date

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Signature of the Spouse or Partner of Patient   Date