



FINANCIAL ASSISTANCE APPLICATION

Last Name Responsible Party:	First Name:	Age:
Home Phone Number:	Cell Number:	
Mailing Address:	City:	State/Zip Code:
Employer:	Work Phone Number:	Monthly Gross Income:
Last Name Spouse:	First Name:	Age:
Home Phone Number:	Cell Number:	
Mailing Address:	City:	State/Zip Code:
Spouse Employer:	Work Phone Number:	Spouse Monthly Gross Income:
Responsible Party's Other Income:	Spouse's Other Income:	Annual Gross Household Income:
Number of Children in Family:	Total Number in Family	Age of Dependents:

FINANCIAL ASSISTANCE CHECKLIST

Documented Proof of All Income

Most Recent Federal Tax Return – If claimed as dependent by someone else, must provide claimants most recent tax return.

3 Months Current Pay Stubs – Must include Responsible Party and Spouse

Other Sources of Income – Attach Supporting Documents

- Alimony
- Child Support
- Disability
- Food Stamps/Housing
- Life Insurance
- Pension
- Railroad Retirement
- Social Security Insurance
- Unemployment
- VA Assistance
- Workers Compensation
- Other

I acknowledge the information given to Crook County Medical Services District is true and correct to the best of my knowledge.

Responsible Party Signature: _____ Date: _____

Spouse Signature: _____ Date: _____