

**NORTHWOOD DEACONESS HEALTH CENTER
PATIENT FINANCIAL ASSISTANCE
ELIGIBILITY DETERMINATION FORM**

DATE OF REQUEST: _____ **PATIENT'S NAME:** _____

NAME: _____ **SPOUSE'S NAME:** _____

ADDRESS: _____ **PHONE:** _____

FINANCIAL ASSISTANCE REQUESTED BY: _____

NUMBER OF PERSONS IN THE FAMILY: _____

FAMILY INCOME LAST 12 MONTHS: _____

(verification through last year's tax return or other official verification required)

FAMILY INCOME PROJECTED NEXT 12 MONTHS: _____

EMPLOYER'S NAME, ADDRESS & PHONE; AND OCCUPATION: _____ **SPOUSE'S:** _____

I AM SEEKING FINANCIAL ASSISTANCE FOR SERVICES _____ **ALREADY/** _____ **NOT YET RENDERED.**

FURTHER EXPLANATION: _____

I understand that the information which I submit is subject to verification by NDHC and subject to review and determination by applicable personnel at NDHC. I certify that the above information is true and correct.

Signature of Requester

