

OUTSTANDING DEBT AND LIABILITIES

Please list all loans and credit accounts owed. Include the creditor name, amounts, and monthly payments. It is very important to list all physician and other medical indebtedness. If necessary, use another sheet of paper and attach it to the application.

Creditor / Company Owed	Balance / Amount Owed	Monthly Payment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIVING EXPENSES

Please list the approximate household monthly expense for the following.

	Payee	Monthly Payment
Rent / Mortgage	_____	_____
Food	_____	_____
Electricity / Gas	_____	_____
Telephone	_____	_____
Medication / Drugs	_____	_____
Television / Internet	_____	_____
Property Taxes (Annual)	_____	_____
Insurance Premium	_____	_____
Insurance Premium	_____	_____
Insurance Premium	_____	_____
Other - Define	_____	_____
Other - Define	_____	_____
Other - Define	_____	_____

CONSIDERATIONS

The application form must be completed in full. If the application cannot be completed in full, provide a written explanation as to why. Any other information that is felt to be relevant and important to this application can be noted on a separate piece of paper and attached to this form.

Without a complete application or acceptable explanation, the application will be subject to denial.

All financial assistance is provided at the sole discretion of Noland Health Services and can be revoked at any time. A review and final decision will be made within 30 days of the receipt of the completed application and a notice of decision will be mailed to the applicant.

Applicant / Patient Signature

Date

If signed by applicant, relation to the patient

