



Name: _____ SS#: _____ Birthdate: _____

Address: _____ Telephone: _____

Former Address: _____

(If at present address less than two years)

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name: _____ SS#: _____

Number in Household: _____ Number of Dependent Children at Home: _____ Ages: _____

MONTHLY HOUSEHOLD INCOME PLEASE PROVIDE PROOF OF INCOME

Table with 5 columns: Name of Person Employed (or receiving SSI), Name of Employer (Please indicate if SSI), Length of Employment, Monthly Gross \$, Monthly Net \$

All Other Income Not Listed Above (List Sources):

Table with 2 columns: Monthly Gross \$, Monthly Net \$

TOTAL MONTHLY INCOME \$ _____

MONTHLY LIVING EXPENSES

Table with 2 columns: Expense Category, Monthly Payment

TOTAL MONTHLY LIVING EXPENSE \$ _____

ASSETS CASH AND INVESTMENTS

Table with 3 columns: Bank and Branch, Type of Account, Account Balance

TOTAL ASSETS \$ _____

CHARGE CARDS MASTERCARD, VISA, DEPARTMENT STORES

Bank and Branch	Account Balance	Monthly Payment
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
TOTAL CHARGE CARD EXPENSE (A)		\$ _____

OTHER CREDITORS AUTO/RV LOANS, ETC.

Bank and Branch	Account Balance	Monthly Payment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
TOTAL OTHER CREDITORS EXPENSE (B)		\$ _____

MEDICAL CREDITORS

Provider Name	Account Balance	Monthly Payment
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	_____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
TOTAL MEDICAL CREDITORS EXPENSES (C)		\$ _____

The above information is warranted to be true.

I hereby authorize any Credit Bureau or other investigative agency employed by Community Cancer Center to investigate the references herein listed or statements of other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Date: _____ Signature of Applicant: _____

FOR OFFICE USE ONLY:

Estimated Patient Responsibility: CCC \$ _____ RRO \$ _____

Discount Approved/Denied: ED: _____ Physician: _____ Denied

Approved Based on Income _____% Approved Based on Income/Expense _____%

Patient informed by: Letter Phone In Person By _____ on _____ (Date)