Center for Family Medicine

Financial Assistance Application

Name: ______________________ Account Number: ______________________

SSN: ______________________ Spouse: ______________________

Address: ______________________ SSN: ______________________

______________________ Phone Number: ______________________

Number in Household: ______________________

Cash in Bank: $ ______________________

Stocks & Bonds: $ ______________________

Home Value: $ ______________________

Other Real Estate: $ ______________________

Cash on Hand: $ ______________________

Monthly Income	Self	Spouse
Gross Income	$	
Veteran's Pension	$	
Disability	$	
Retirement	$	
Social Security	$	
Unemployment	$	
Work Comp	$	
Alimony/Child Support	$	
Rental Income	$	
TOTAL:	$	

Liabilities	Unpaid Balance	Monthly Payments
Name of Creditor:	$	
Bank Loan	$	
Auto Loan	$	
Charge Cards	$	
Doctors/Dentists	$	
Hospitals	$	
Collection Agencies	$	
Alimony/Child Support	$	
Other:	$	
TOTAL:	$	

Vehicles:

Year: ________ Value: $ ________ Make/Model: ________

Year: ________ Value: $ ________ Make/Model: ________

Other Investments/Savings: $ ______________________

Monthly Expenses	
Rent	$
Food	$
Insurance	$
Clothing	$
Phone	$
Utilities	$
Car Expenses (not pymnt)	$
Medication	$
TOTAL:	$

Do you anticipate receiving any gifts, inheritances or money from land sales or any other source in the near future? No ❑ Yes ❑

If Yes, please explain: ______________________

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Have you ever received any welfare benefits from any governmental or other third party source (county welfare, food stamps, Medicaid, Emergency Energy Assistance,etc)? No ❑ Yes ❑
If Yes, please state the nature of relief received and the time period that you received such benefits:

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Proposed Payment Plan:

Please attach a copy of your most recent tax return

I (we) hereby acknowledge that the information given to Center for Family Medicine, Sioux Falls, SD as in the Financial Application indicated as true and correct and given for the purposes of obtaining credit, and authorizes release of information from my financial institution and creditors to the Center for Family Medicine or its representatives.

SIGNATURE: ______________________ DATE: ______________________