Sunflower Neonatology Associates
Financial Hardship Application

Name of Responsible Party: _____ **Date of Birth:** _____

Relationship to Patient: _____

Spouse's Name: _____ **Date of Birth:** _____

Patient(s) Name: 1) _____ **Date of Birth:** _____

2) _____ **Date of Birth:** _____

3) _____ **Date of Birth:** _____

Address: _____ **City & State:** _____ **Zip:** _____

Phone number(s): **Home** _____ **Cell** _____

Number of Family Members in Household: _____

List Dependents:	Date of Birth

Employer: _____

Address of Employer:

City: _____ State: _____

If unemployed, how long? _____

Spouse's employer: _____

Spouse's employers address:

City: _____ State: _____

If unemployed, how long? _____

MONTHLY INCOME AND SOURCE

Monthly Salary (Gross):
Public Assistance Benefits:
Unemployment Benefits:
If yes, how much are you receiving per week?: _____
Number of weeks left?: _____
Social Security Benefits:
Workman's Compensation:
Child Support:
Other (alimony, rental income, etc):

EXPENSES

Rent:	
Home Value:	_____
Amount remaining on loan:	
Car Payment:	_____
Amount remaining on loan:	
Car Payment:	_____
Amount remaining on loan:	
Amount paid for alimony, child support:	
Credit Cards (total per month):	_____
Available credit:	
Other loans:	

☐ last years tax return
☐ last 2 bank statements for all active accounts
☐ copies of unemployment checks for last 2 months
☐ copies of paystubs for last 2 months

By signing below, I certify that to the best of my knowledge: (1) I have applied for all government assistance that may be available to me for payment of my debt to Sunflower Neonatology Associates; and (2) all information furnished in or with this application is true and correct. **By signing below, I authorize Sunflower Neonatology Associates to obtain credit bureau reports and make other credit inquiries it determines necessary to verify the submitted information and, until all amounts owed are paid in full, I further authorize them to obtain additional credit reports to verify continuing financial hardship.** I understand that submission of false or inaccurate information will jeopardize my consideration for a financial hardship discount. I acknowledge that completion of this application does not guarantee any discount, payment plan or forgiveness of debt.

Signed: _____

Sunflower Neonatology's use only:

Reviewed by:_____ Date: _____

Approved for: _____ Date: _____