Jackson Hospital & Clinic
Financial Assistance Program Application

Patient Acct # ______________________ Date of application: ________________

Patient Information: **Spouse/Parent/Guarantor**:

Name:	Name:
Address	Address
City	City
State/Zip	State/Zip
SS#	SS#
Phone	Phone
Employer	Employer
Address	Address
City	City
State/Zip	State/Zip
Work Phone	Work Phone
Length of Employment	Length of Employment
Supervisor	Supervisor

(Over)

Resources:

Checking: yes ____ no ____

Savings: yes ____ no ____

Vehicles:

Year _________ Make ______________________ Model __________________

Year _________ Make ______________________ Model __________________

Year _________ Make ______________________ Model __________________