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