

SISKIN GRANT FUND APPLICATION

PATIENT NAME: _____ DATE: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE'S NAME: _____

EMPLOYER: _____ TITLE: _____ SERVICE: _____

HOW LONG AT PRESENT ADDRESS? _____ Total # of Dependents (Include Yourself) _____

SPOUSE'S EMPLOYER: _____ TITLE: _____ SERVICE: _____

ASSETS			
	DESCRIPTION	BALANCE OWED	CASH VALUE
CHECKING ACCOUNT <i>(List Bank & Acct #)</i>			
SAVINGS ACCOUNT <i>(List Bank & Acct #)</i>			
HOME OWNERSHIP <i>(Mortgae/Rent)</i>			
OTHER REAL ESTATE OWNED			
AUTOMOBILE MAKE AND YEAR			
AUTOMOBILE MAKE AND YEAR			
PERMANENT LIFE INSURANCE			
OTHER <i>(EXPLAIN)</i>			
OTHER <i>(EXPLAIN)</i>			
TOTALS			

INCOME*

YOUR GROSS SALARY	\$	PER MONTH	TAKE HOME PAY:	\$
SPOUSE'S GROSS SALARY	\$	PER MONTH	TAKE HOME PAY:	\$
OTHER INCOME <i>(ITEMIZE)</i>	\$	PER MONTH	TAKE HOME PAY:	\$
OTHER INCOME <i>(ITEMIZE)</i>	\$	PER MONTH	TAKE HOME PAY:	\$
EXPLAIN OTHER INCOME				

***VERIFICATON IS REQUIRED PLEASE ATTACH LAST INCOME TAX RETURN, a copy of most recent bank statements and any other documents to show proof of income.**

***** ALL INFORMATION OBTAINED IS CONFIDENTIAL *****

DEBTS*

*Verification may be required	TOTAL OWED	MONTHLY PAYMENTS
HOUSEHOLD: Mortgage _____ Rent _____		
UTILITIES: Electric, Gas, Water		
Telephone		
Food		
AUTOMOBILE: Payments		
Insurance		
CHARGE ACCOUNTS (List Cards and Store Accts):		
LOANS: Finance Company		
Bank		
Credit Union		
MISCELLANEOUS (Explain):		

DO YOU HAVE ANY JUDGEMENTS OR LIEN OUTSTANDING? YES ___ NO ___

I certify that the information on this application is a true and complete statement of facts according to my best knowledge and belief. I understand that falsification or failure to provide complete information requested on this application or failure/void any payment agreement already in effect I understand I will be personally responsible for any charges in excess of the approved grant amount below and for all charges for care received beyond the services or dates of service approved below.

Signed _____ Date _____

RECOMMENDATION: _____ **DATE:** _____

REVIEWED BY: _____ **DATE:** _____

APPROVED BY: _____ **DATE:** _____

GRANT AMOUNT APPROVED: \$ _____

APPROVED FOR THE FOLLOWING SERVICES: _____

APPROVED FOR THE FOLLOWING DATES OF SERVICE: From: _____ To: _____