



**SUWANNEE RIVER BREAST CANCER
AWARENESS ASSOCIATION, INC.**
a Florida not-for-profit corporation
CHARITY CARE APPLICATION

Name: _____ Birthdate: ____/____/____ Social Security No: ____-____-____
(Patient/Applicant)

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Marital Status: _____ Number of Dependent Children: _____

MONTHLY INCOME

Patient's Employer: _____ Self-employed: Spouse's Employer: _____ Self-employed:

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ City: _____

How long? _____ to _____ Gross Wages: \$ _____ How long? _____ to _____ Gross Wages: \$ _____

Unemployed: How long? _____ Unemployed: How long? _____

Social Security Income: \$ _____ Social Security Income: \$ _____

Unemployment Compensation: \$ _____ Unemployment Compensation: \$ _____

Worker's Compensation: \$ _____ Worker's Compensation: \$ _____

Child Support/Alimony Received: \$ _____ Child Support/Alimony Received: \$ _____

Public Assistance/Housing: \$ _____ Public Assistance/Housing: \$ _____

Food Stamps Received: \$ _____ Food Stamps Received: \$ _____

Medicare/Medicaid Available: \$ _____ Medicare/Medicaid Available: \$ _____

Grants Received: \$ _____ Grants Received/Available: \$ _____

Pension Received: \$ _____ Pension Received: \$ _____

Rental Income Received: \$ _____ Rental Income Received: \$ _____

Investment Interest/Dividends: \$ _____ Investment Interest/Dividends: \$ _____

Source: _____ Source: _____

Other Income/Benefits: \$ _____ Other Income/Benefits: \$ _____

Source: _____ Source: _____

Source: _____ Source: _____

TOTAL: \$ _____ TOTAL: \$ _____

Do any other persons contribute financially to the family? Yes No If YES, amount: \$ _____ per _____

ASSETS:

Checking Acct(s): \$ _____ Cash on hand: \$ _____

Bank/Institution: _____ Stocks/Bonds: \$ _____

Savings Acct(s): .. \$ _____ Money Market(s) or CD(s): \$ _____

Bank/Institution: _____ IRA or 401k: \$ _____

List other assets: _____ Primary Residence Value: \$ _____

_____ Property (Land, 2nd Residence) Value: \$ _____

DEBTS/EXPENSES:

Liabilities:

Owing	To Whom	Monthly Payment	Balance	OTHER EXPENSES (including medical):		
Mortgage/Rent:	_____	_____	_____	_____	_____	_____
Real Estate:	_____	_____	_____	_____	_____	_____
Properties:	_____	_____	_____	_____	_____	_____
Bank Loan:	_____	_____	_____	_____	_____	_____
Auto Loan:	_____	_____	_____	_____	_____	_____
Credit Cards:	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

The following documents must be provided for patient:

Federal Income Tax Return: YES NO If NO, please explain: _____

Proof of Public Assistance (Food Stamps, Housing Assistance, Medicare/Medicaid): YES NO If NO, please explain: _____

Current Bank Statement (Past 90 days): YES NO If NO, please explain: _____

Statements of Income from other sources (Social Security, Pension, Grants, Worker's Comp, Unemployment Comp): YES NO If

NO, please explain: _____

This is to advise that I have pursued all other avenues possible for payment, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations: therefore, I hereby request Suwannee River Breast Cancer Awareness Association, Inc. make a determination of my eligibility for their Charity Care Program. I understand that the information I submit concerning my income, family size, assets, expenses and medical bills is subject to verification by Suwannee River Breast Cancer Awareness Association, Inc. I also understand that if the information I submit is now or at any time in the future determined to be false, such determination will result in current and/or retroactive denial of Charity Care and I will be liable for charges for services rendered. I certify that all of the information in this form is true and correct. Incomplete and fraudulent applications will be denied. I acknowledge that by submitting this completed for consideration, I can withdraw said application at any time and the Suwannee River Breast Cancer Awareness Association, Inc. is in no way obligated to distribute any funds for my benefit.

Patient or Responsible Party Signature

Date



Return Application to:

**Suwannee River Breast Cancer Awareness Association, Inc.
P.O. Box 1394
Lake City, Florida 32056**

