

THE CHARLOTTE HUNGERFORD HOSPITAL  
APPLICATION FOR FREE BED FUND ASSISTANCE

INCOME/EXPENSES WORKSHEET [attach additional pages if needed]

1. NAME \_\_\_\_\_ PHONE#: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

2. INCOME:NUMBER OF MEMBERS IN HOUSEHOLD: \_\_\_\_\_ AGES \_\_\_\_\_  
TOTAL MONTHLY INCOME NET: \_\_\_\_\_  
SOURCE: \_\_\_\_\_ IF UNEMPLOYMENT - WHY? \_\_\_\_\_

3. EXPENSES - NECESSITIES:	\$/MONTH OR ANNUALLY	BALANCE DUE
RENT/MORTGAGE	_____	_____
INSURANCE/TAXES-MORTGAGE	_____	_____
FOOD	_____	_____
MEDICAL	_____	_____
PHARMACY	_____	_____
DOCTORS _____	_____	_____
_____	_____	_____
CAR PAYMENTS	_____	_____
CAR REPAIRS & GAS	_____	_____
CAR INSURANCE AND TAXES	_____	_____
CHILD CARE	_____	_____
TELEPHONE	_____	_____
ELECTRIC	_____	_____
GAS OR ENERGY (OIL)	_____	_____
WATER	_____	_____
EXPENSES - COMFORT ITEMS:		
CABLE	_____	_____
CELL PHONE	_____	_____
DEBTS: CREDIT CARDS:	_____	_____
OTHER EXPENSES - LIST WHAT	_____	_____
_____	_____	_____
TOTAL EXPENSES:	_____	_____
TOTAL MONTHLY NET INCOME	_____	
LESS-TOTAL MONTHLY EXPENSES	_____	
REMAINING INCOME	_____	

FINANCIAL DOCUMENTS REQUIRED [if applicable]

- \_\_\_\_\_ Federal Tax Return and W-2 Years: \_\_\_\_\_
  - Income Verification - Examples included, but are not limited to:
  - \_\_\_\_\_ Last 2 pay stubs for patient and/or spouse
  - \_\_\_\_\_ Social Security check verification
  - \_\_\_\_\_ Disability check verification
  - \_\_\_\_\_ Copy of Certificate of Deposits Held
  - \_\_\_\_\_ Copy of IRA, Mutual Fund or 401k
  - \_\_\_\_\_ Interest earned from stocks and bonds
  - \_\_\_\_\_ Recent Savings Account Statement
  - \_\_\_\_\_ Recent Checking Account Statement
  - \_\_\_\_\_ Copy of pension check
  - \_\_\_\_\_ Alimony check copy
  - \_\_\_\_\_ Child support check copy
- \_\_\_ Attach any information from  
Department of Social Services  
re: Approval, Spenddown, Denial

I HEREBY ACKNOWLEDGE THAT THE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND THAT ANY MISREPRESENTATIONS OF INFORMATION WILL RESULT IN REPAYMENT OF ANY FINANCIAL ASSISTANCE GRANTED. IN CONJUNCTION WITH THIS APPLICATION THE HOSPITAL MAY VERIFY THE ABOVE INFORMATION THROUGH THE USE OF A CREDIT BUREAU.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_