

Exhibit C
Financial Assistance Form
DEKALB REGIONAL
M E D I C A L C E N T E R

Charity Care/Financial Assistance Program Application

Page 1 of 2

Patient Account Number: _____ Date of Application _____

PATIENT INFORMATION

PARENT/GUARANTOR/SPOUSE

Name _____

Name _____

Address _____

Address _____

City _____

City _____

State/Zip _____

State/Zip _____

SS# _____

SS# _____

Employer _____

Employer _____

Address _____

Address _____

City _____

City _____

State/Zip _____

State/Zip _____

Work Phone _____

Work Phone _____

Length of Employment _____

Length of Employment _____

Supervisor _____

Supervisor _____

RESOURCES

Checking: yes___ no___ Vehicle 1: Yr_____ Make_____ Model_____

Savings: yes___ no___ Vehicle 2: Yr_____ Make_____ Model_____

Vehicle 3: Yr_____ Make_____ Model_____

Cash on hand: \$ _____

