BREAST CARE

Breast Care Fund Financial Assistance Application

1. APPLICANT (GUARANTOR) INFORMATION

DATE OF APPLICATION ___________

Marital Status ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated

Last Name ____________________ First Name ____________________ Middle Initial ______

Primary Phone Number (_____) ____________ U.S. Citizen ☐ YES ☐ NO

Date of Birth ____________ No. of Dependents (under 18 yrs old) ______ Ages of Dependents ____________

Address ____________________ City ____________ State ____ County ____________ Zip Code ________
(do not list PO Box)

Place of employment ____

2. INCOME VERIFICATION Please provide gross monthly income

Monthly Income Sources	Applicant	Spouse (if applicable)	Combined Monthly Income
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
State Assistance (ie: food stamps)	$	$	$
Other (s)	$	$	$
Total combined gross monthly income			**$**

Do you have health insurance? Yes or No (circle one)

If yes, insurance carrier: ____

Have you applied for Medicaid? Yes or No (circle one)

3. SIGNATURE

I certify that all information is valid and complete and hereby authorize Holland Hospital to request a credit report and/or verify any of the above information as deemed necessary.

Applicant Signature ____________________________ Date ________

Return completed application with all verification to:

Holland Hospital Breast Care
844 Washington Ave, Entrance C, Suite 2100
Holland MI 49423
Phone: (616) 355-3865
Fax: (616) 396-2453

hollandhospital.org

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