Medical Expense Loan Program application ❏ Individual ❏ Joint

Patient(s) _____

Account number(s) _____ Total balance of all accounts $ _____

Applicant Relationship to patient_____

Last name _____ First name _____ M.I. _____ Birthdate _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Mailing address (if different)_____ City _____ State _____ ZIP _____

Telephone _____ Cell _____ Years at this address _____

Email address _____

❏ Employed

Employer _____ Employer's address _____

Position _____ Years employed _____ Gross wages per month $ _____ Telephone_____

Other sources of income _____ Amount per month $ _____

❏ Unemployed

Sources of income (disability, retirement, etc.) _____ Amount per month $ _____

Joint Applicant Relationship to applicant _____ Relationship to patient_____

Last name _____ First name _____ M.I. _____ Birthdate _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Mailing address (if different)_____ City _____ State _____ ZIP _____

Telephone _____ Cell _____ Years at this address _____

Email address _____

❏ Employed

Employer _____ Employer's address _____

Position _____ Years employed _____ Gross wages per month $ _____ Telephone_____

Other sources of income _____ Amount per month $ _____

❏ Unemployed

Sources of income (disability, retirement, etc.) _____ Amount per month $ _____

The above information is true and accurate to the best of my knowledge. Applicant(s) signature(s) _____