Memorial Sloan-Kettering Cancer Center

Financial Assistance Questionnaire

Office Use Only
MRN: ___________________

Last Name: ___________________________________ First Name: ________________________________
Address ____
City:_________________________________ State:________________________ Zip:___________________
Telephone Number _____________________________ Cell: _______________________________________
Family size / number in household ______________________

List household members:

Last Name	First	Relationship	Age	Occupation	Annual Gross Wages

Household Annual Income

Type of Income	Patient Income	Spouse Income
Wages	$	$
Social Security Payment	$	$
Unemployment Compensation	$	$
Disability	$	$
Workers Compensation	$	$
Alimony/child support	$	$
Dividends/interest/rentals	$	$
Other Income	$	$
Total		

Family Resources

Type	Bank	Amount
Savings Account		
Checking Account		
Mutual Funds (Market Value)		
Stocks & Bonds (Market Value)		
Certificate of Deposit(s)		

Residences – Primary

☐ Rent (Monthly Payment) __________________________
☐ Home (Monthly Mortgage Payment) _________________
Bank: ____

Secondary

☐ Rent (Monthly Payment)_______________________
☐ Home (Monthly Mortgage Payment)_____________
Bank:____

Comments

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I affirm that the information provided by me is correct to the best of my knowledge. I fully understand my responsibility for the truthfulness of these statements. I recognize that all information provided is subject to verification.

Guarantor's Signature: ______________________________________ Date:____________

Upon submission of this application you do not have to make any payment to the hospital until the hospital sends you a letter with its decision.