



Financial Assistance Co-Applicant Signature Form

DATE OF APPLICATION: _____

APPLICANT (GUARANTOR) INFORMATION

Last Name	First Name	Date of Birth
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CO-APPLICANT INFORMATION

Last Name	First Name	Date of Birth
Relationship to Patient		

I certify that all information provided on the Stanford Health Care Financial Assistance Application is valid and complete and hereby authorize Stanford Health Care to request and/or verify any of the information provided as deemed necessary.

Please sign in the signature box to confirm that you understand the terms of the application. Please upload and attach this document to the Guarantor's application in MyHealth.

SIGNATURE

Co-Applicant	Date
_____	_____