

Financial Assistance Application

affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed. I understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.	Name:			Account Number:	
Phone: SSN:	Address:				
HOUSEHOLD INFORMATION: Please list all members of the household, including patient, spouse and any biological/legally adopted children under 18 years old. First and Last Name	City:		State:	Zip Code:	
First and Last Name Relationship to Patient Self Total Gross Income in the 3 Months Prior to the Date of Service Self Total Gross Income in the 12 Months Prior to the Date of Service Self Total Gross Income in the 12 Months Prior to the Date of Service Self Total Gross Income in the 12 Months Prior to the Date of Service Self Total Gross Income in the 12 Months Prior to the Date of Service Self Total Gross Income in the 12 Months Prior to the Date of Service Self Prior Income, how you are being supported? Did you have no income, how you are being supported? Did you have health insurance on the date of service? \(\bar{\text{Normal Months Prior}} \) No \(\bar{\text{Yes}} \) Yes (Value \(\bar{\text{Does anyone in your household have a checking and or savings account? \(\bar{\text{Normal Months Prior}} \) No \(\bar{\text{Yes}} \) Yes (Value \(\bar{\text{Does anyone in your household have any other assets? \(\bar{\text{Normal Months Prior}} \) No \(\bar{\text{Yes}} \) Yes (Value \(\bar{\text{Does anyone in your household have any other assets? \(\bar{\text{Normal Months Prior}} \) No \(\bar{\text{Yes}} \) Yes (Value \(\bar{\text{Does anyone in your household have any other assets? \(\bar{\text{Normal Months Prior}} \) No \(\bar{\text{Yes}} \) Yes (Value \(\bar{\text{Does anyone in your household have any other assets? \(\bar{\text{Normal Months Prior}} \) No \(\bar{\text{Yes}} \) Yes (Value \(\bar{\text{Does Anyone in your household have any other assets? \(\bar{\text{Normal Months Prior}} \) Provide the following for each member of the household: \[\bar{\text{Common Months Prior}} \) The household: \[\bar{\text{Common Months Prior}} \) The household have a checking for each member of the household: \[\bar{\text{Common Months Prior}} \) The household have a checking for each member of the household: \[\bar{\text{Common Months Months Prior}} \) The ho	Phone:			SSN:	
First and Last Name Relationship to Patient Age/DOB Relationship to In the 3 Months Prior to the Date of Service Self Self If you have no income, how you are being supported? Did you have health insurance on the date of service? □ No □ Yes (Provide card copy with application) Does anyone in your household have a checking and or savings account? □ No □ Yes (Value □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ Does anyone in your household have any other assets? □ No □ Yes (Type/Value: □ Does anyone in your household have any other assets? □ No □ Yes (Provide card copy with application) For Income/Assets listed above, you must provide the following for each member of the household: □ Does anyone in your household have a checking for each member of the household: □ Does anyone in your household have a checking for each member of the household: □ Does anyone in y			the household, inc	luding patient, spouse and	any
Did you have no income, how you are being supported? Did you have health insurance on the date of service? Does anyone in your household have a checking and or savings account? Does anyone in your household have any other assets? No Yes (Type/Value:	First and Last Name		Age/DOB	in the 3 Months Prior	in the 12 Months Prior to the Date of
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Does anyone in your household have any other assets? No Yes (Type/Value: For Income/Assets listed above, you must provide the following for each member of the household: Employment = paystubs showing gross income for 3 or 12 months prior to the date of service Self Employment = Complete tax forms from most recent filing including Schedule C Social Security/Pension/Disability = Most recent benefit letter Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.) Checking/Savings = Current 30-day statement for each account By signing this document: I affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed. I understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.				rovide card copy with ap	olication)
For Income/Assets listed above, you must provide the following for each member of the household: Employment = paystubs showing gross income for 3 or 12 months prior to the date of service Self Employment = Complete tax forms from most recent filing including Schedule C Social Security/Pension/Disability = Most recent benefit letter Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.) Checking/Savings = Current 30-day statement for each account By signing this document: affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed. understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.	· · · · · · · · · · · · · · · · · · ·	•	•	`	
□ Employment = paystubs showing gross income for 3 or 12 months prior to the date of service □ Self Employment = Complete tax forms from most recent filing including Schedule C □ Social Security/Pension/Disability = Most recent benefit letter □ Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.) □ Checking/Savings = Current 30-day statement for each account By signing this document: □ affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed. □ understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.	Does anyone in your household	have any other asset	ts? □ No □ Yes ((Type/Value:	
	☐ Employment = paystubs show ☐ Self Employment = Complete ☐ Social Security/Pension/Disab ☐ Other = Proof of any other inc ☐ Checking/Savings = Current 3 By signing this document: I affirm all the answers on this applifraudulent, the decision to provide for I understand that the information I seemed to see the second seemed to seemed to see the second seemed to seemed to see the second seeme	ving gross income for tax forms from most bility = Most recent be come (unemployment 30-day statement for cation are true. Should inancial assistance may	a subsequent review be reversed and to	orior to the date of serviced ding Schedule C ds, interest, rental income ew reveal that any information in the responsible party will be	e, etc.) on provided was
	required. Patient Signature:			Date:	