



Financial Assistance Application



Date/s of Service: _____

Applicant Name: _____ Last Four Digits of SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Cell): _____ Phone (Alternate): _____

Place of Employment: _____

Health Insurance Plan: YES NO Name of Insurance: _____

Please list all Persons living in the household

	Name	Relationship to Applicant	DOB:
1		<input checked="" type="checkbox"/> Applicant	
2		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
3		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
4		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
5		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
6		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
7		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	
8		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other: _____	

Monthly Household Income

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment and public aid. This facility does not discriminate due to an individual's inability to pay or based on an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.

Income Source	SELF	SPOUSE	OTHER	TOTAL
Gross Wages & Salary				\$
Social Security, Pension, Annuity, VA Benefits				\$
Alimony, Child Support, Military Allotments				\$
Business Income from Self Employment				\$
Rent, Interest, Dividends				\$
Other Income (Specify):				\$
TOTAL INCOME:				\$

I certify that the family size and income information shown above, and the verification documents provided are correct.

NAME (PRINT): _____ SIGNATURE: _____ DATE: _____

Financial Assistance Application VERIFICATION Form

Verification Checklist (Attach ALL Copies)

Identification/ Address Verification Driver's License, Birth Certificate, Employment ID, or SS Card	<input type="checkbox"/> Yes <input type="checkbox"/> No
Income Verification Three most recent Pay Stubs, or Last year's Tax Return, Approval/denial for Unemployment Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Coverage Verification Insurance Card(s), or Certificates of Credible Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Office Use Only	DOB:	Date App Received:	Date Verification Complete:
Patient Name:			
Application Recommendation: <input type="checkbox"/> Approval @ _____% <input type="checkbox"/> NOT Approved <input type="checkbox"/> Outside Income Guidelines <input type="checkbox"/> No Applicant Response <input type="checkbox"/> Missing Info	Approval Signatures		
	Clerk	Date	
	CEO	Date	
	CFO	Date	