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		☒ Applicant	
2		☐Spouse ☐Dependent ☐Other:_____	
3		☐Spouse ☐Dependent ☐Other:_____	
4		☐Spouse ☐Dependent ☐Other:_____	
5		☐Spouse ☐Dependent ☐Other:_____	
6		☐Spouse ☐Dependent ☐Other:_____	
7		☐Spouse ☐Dependent ☐Other:_____	
8		☐Spouse ☐Dependent ☐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	☐**Yes** ☐**No**
Income Verification Three most recent Pay Stubs, or Last year's Tax Return, Approval/denial for Unemployment Compensation	☐**Yes** ☐**No**
Insurance Coverage Verification Insurance Card(s), or Certificates of Credible Coverage	☐**Yes** ☐**No**
Medicaid Coverage Application made or Evidence of denied coverage	☐**Yes** ☐**No**

For Office Use Only	DOB:	Date App Received:	Date Verification Complete:
Patient Name:			

Application Recommendation:	**Approval Signatures**	
☐ Approval @_____%	Clerk	Date
☐ NOT Approved	CEO	Date
☐Outside Income Guidelines ☐No Applicant Response ☐Missing Info	CFO	Date