



Financial Assistance Application

Date/s of Service: _____

Applicant Name: _____

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.

Income Source	SELF	SPOUSE	OTHER	TOTAL
Gross Wages & Salary				\$
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)

**Note: The information below is required for your application to be considered. Missing information may cause your application to be returned or denied.

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, Bank Statement, and 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