



# 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.*

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):				\$
<b>TOTAL INCOME:</b>				<b>\$</b>

**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)

<b>Identification/ Address Verification</b> Driver's License, Birth Certificate, Employment ID, or SS Card	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Income Verification</b> Three most recent Pay Stubs, or Last year's Tax Return, Approval/denial for Unemployment Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Insurance Coverage Verification</b> 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	<b>Approval Signatures</b>		
	Clerk	Date	
	CEO	Date	
	CFO	Date	