Alliance
Physical Therapy Partners

Application for Charity Funding

ATTENTION: ACCOUNT SERVICES

As provided for in Federal law, I hereby request that Agility Health LLC make a written determination of my eligibility for uncompensated services at Agility Health LLC. I understand that the information, which I submit concerning my income and family size, is subject to verification by Agility Health LLC and if the information I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services that I will be liable for charges for services provided.

Name: _____
First Middle Last

Address: _____
Number & Street City State Zip

Telephone Number: (_____) _____ Employer: _____

Patient Name: _____ Date of Birth: _____
(If different than applicant)

"*Verification of income figures is required".* Income is defined as gross income before taxes. Use the gross income of the household, which claims the patient on their Federal Income Tax Return. (If an ex-spouse claims your child on his/her federal tax returns, you must report your ex-spouse's income here).

Income based on the following supporting incomes (Please provide copies of documentation as listed below):

Indicate Documentation Provided ✓	
Copy of Most Recent Federal Tax Return	_____
Wages	_____
Farm or Self Employment	_____
Public Assistance	_____
Social Security	_____
Unemployment Compensation	_____
Worker's Compensation	_____
Strike Benefits	_____
Alimony	_____
Child Support	_____
Pensions	_____
Income from dividends, Interest, Rent	_____

Number of Exemptions / Family Members claimed on tax return of household of applicant: _____

List any special circumstances or significant expenses that should be considered with this application.

_____

_____

I affirm that the above information is true and correct to the best of my knowledge.

_____ _____
Signature of applicant / responsible party Date

Return form to: Agility Health LLC, 607 Dewey Ave. NW, Suite 300, Grand Rapids, MI 49504

Alliance
Physical Therapy Partners

Determination for Charity Funding

(To be completed by Agility Health)

Patient Name: _____

Account Number: _____

Office Site: _____

Date Received: _____

Date of Determination: _____

Insurance Information

Name: _____

Benefit Covered: _____Y _____N

Copay: _____

Deductible: _____

Determination: _____ Denied
_____ Pending Initial Evaluation and Treatment
_____ Approved for Additional Treatment _____ Visits

_____ _____
Signature of Patient Date

_____ _____
Signature of Clinic Business Coordinator Date

_____ _____
Signature of Revenue Cycle Manager Date

_____ _____
Signature of Regional Director Date