Background pattern

Description automatically generated with low confidence **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.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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)**

\*\*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 | Yes No |
| **Income Verification**  Three most recent Pay Stubs, Bank Statement, and 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| For Office Use Only | DOB: | Date App Received: | Date Verification Complete: | |
| Patient Name: |
| Application Recommendation:  Approval @\_\_\_\_\_\_\_\_\_%  NOT Approved  Outside Income Guidelines No Applicant Response Missing Info | **Approval Signatures** | | | |
| Clerk | | | Date |
| CEO | | | Date |
| CFO | | | Date |