

Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care or sliding fee scale program) at _____.

You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. It is the policy of _____ to provide essential services regardless of the patient's ability to pay. _____ offers discounts based on family size and income.

Please complete the following information and return to the front desk to determine if you or your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

If you have questions or need help completing this application:

You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family's gross monthly income (income before taxes and deductions)**
Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide documentation for family income**
- Attach additional information if needed**
- Sign and date the form**

Mail or fax completed application with all documentation to: _____ . Be sure to keep a copy for yourself.

To submit your completed application in person:

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

**We want to help. Please submit your application promptly!
You may receive bills until we receive your information.**

Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name	Patient last name
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not listed (_____)	Birth Date	
Person Responsible for Paying Bill	Relationship to Patient	Birth Date
Mailing Address _____ _____		Main contact number(s) () _____ () _____
City	State	Zip Code
		Email Address: _____

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. _____ will also consider non-related household members when calculating family size so please include information for all household members.

FAMILY SIZE _____

Attach additional page if needed

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain* _____)

Charity Care/Financial Assistance Application Form – confidential

INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with a brief explanation.

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that _____ may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Person Applying

Date

Office Use Only

Patient Name: _____

Percentage of FPL: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

This document has been prepared in accordance with the site reference guidelines. It is important to note that it is not endorsed by or affiliated with HRSA.