



Financial Assistance Application

Personal Data:

Date of request:	Acct #:	Date of Service:
Patient name:		
Address:		
City:	State:	Zip:
Telephone:	Alternate Phone:	
Employer:		Number of persons in family:

Family Income: (Please provide copies of your most recent Federal Tax Return with W2's and (3) most recent pay stubs)

Wages	Total per Month	Total for Past Six Months
Self-employment:		
Unemployment Comp:		
Workman's Comp:		
Welfare / Public Assist:		
Child Support / Alimony:		
Disability Income:		
Pensions / Annuities:		
Misc. (interest, rent, etc):		
TOTAL INCOME:		

Check here if you are not required to file federal tax return

Assets: (list assets for family)

Number of Real Estate Properties Owned	
Savings account balance	\$
Checking account balance	\$
Value of Stocks/Bonds	\$

Please attach a copy of your medical assistance notification from Medicaid (whether approved or denied) with this application. Note: Denials for medical assistance due to failure to apply in a timely manner or failure to provide needed information will not be sufficient documentation of ineligibility for those programs.

I affirm that the foregoing statements in this application are true and correct to the best of my knowledge and belief.

Signature of applicant _____

Office use only:

Approved:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Write-off Percentage:
If denied, reason:			
Director Signature:		Date:	